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Evaluation of Education for Senior Healthcare Support Workers (SCQF Level 7) and Assistant Practitioners (SCQF Level 8) in Children and Young People's Health with Optional Pathways

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Executive summary

Introduction

1. This report provides an evaluation of an education programme for Senior Healthcare Support Workers (SHCSWs) (SCQF Level 7) and Assistant Practitioners (APs) (SCQF Level 8) for Children and Young People's Health (CYPH) with optional pathways at a Scottish HEI. The evaluation was commissioned by NHS Education for Scotland (NES), undertaken by a team from the School of Health Sciences at Queen Margaret University Edinburgh, and carried out over 12 months from June 2009 to June 2010.

Evaluation aims and objectives

2. The evaluation aims as confirmed by the NHS Education Scotland Steering Group in June 2009 were to:
 - Evaluate the outcomes of the above education in relation to the 5 key domains of practice
 - Evaluate the appropriateness of the education for the SHCSW & AP roles
 - Explore the impact of the new roles on the individual and services
 - Identify current employment aspirations for completion of the programme

The evaluation objectives were as follows:

- To collect, analyse and report back on the numbers, types and location of students who have undergone the education for Senior Healthcare Support Workers and Assistant Practitioners in Children and Young People's Health and/or who have used the agreed Capability Framework to plan required learning.
- To collect, analyse and report on the content and approaches to delivery and costs of the education provision.
- To collect and analyse feedback and report on findings of the experiences of individuals.

Evaluation design

3. The evaluation design comprised three phases and employed a mixed methods approach. The three phases included the following:
 - A scoping study of programme documentation and ongoing analysis of programme data was undertaken to establish the context in which the programme was being delivered, the characteristics of the planned programme, the actual programme delivered, baseline and outcome data on participants.
 - Surveys of programme participants collected data on demographics, current post, reasons for undertaking the programme, perceived levels of confidence and competence in the five domains of the draft capability framework, academic background, academic level of the programme, and employment patterns.

- A qualitative interview study of participants and stakeholders captured participants' experiences of the programme and explored the nature and perceived impact of the new roles on individuals and services

Evaluation population and sample

4. The student population comprised 32 students in cohorts one and two of the education programme for SHCSWs (SCQF 7) and APs (SCQF 8) in children and young people's health, their mentors and sponsors (senior managers) in the placement settings. The sample size in the first survey in phase two was 20 out of 32 giving a response rate of 62.5%. Only six participants returned a second survey despite a repeat mail-shot and reminders being posted on *Campus Moodle* (a virtual learning environment within the HEI), by the host HEI, at the request of the evaluation team. The volunteer sample in the phase three qualitative study comprised 15 participants, 11 mentors and 6 sponsors across a range of public health, community, school health and acute settings. They were mainly identified through postal questionnaire returns and through interview contact with mentors and sponsors.

Literature review

5. The introduction of HCSWs and APs over the last decade has highlighted the growing need to look closely at clarity of role definition, regulation, the need for supervision and career progression supported by educational programmes that are relevant to the specific context of care (Hewitt-Taylor 2005, NHS Education for Scotland 2009, Smith et al. 2007, Spilsbury et al. 2009, Warne & McAndrew 2004). At this time, there is limited empirical evidence to support or challenge the evolving roles of SHCSWs and APs in supporting registered nurses and midwives, both in the acute and community setting, and in particular in children and young peoples' services. The evidence regarding the impact on outcomes for service users is also limited (Spilsbury & Meyer 2004). The studies and evaluations that explore the educational needs of these workers and HCSWs to support the development of these roles identify the need for supervision in the work place, situated or work based learning, and assessment supported by accredited programmes of study, with opportunities for career progression. NHS Education for Scotland (NES) and the Scottish Social Services Council are currently reviewing this workforce's education and training needs and core standards for practice in response to the key drivers for workforce change (SMCI Associates 2009).

Phase one: Scoping study of the contextual location of the education programme, programme documentation and the student population

6. Phase one provided an analysis of the contextual setting for the education programme, the programme documentation and baseline information about programme participants. The findings from this phase informed data analysis

in phase three and the final evaluation discussion, conclusions and recommendations.

The programme documentation was concise, and included content relevant to the SHCSW and AP roles in CYPH, although content relating to biomedical/physiological knowledge and data-handling should be more explicit. A blended curriculum was proposed that comprised face to face residential study blocks, e-learning, work based learning and an element of peer or group learning. The programme was closely aligned to the Capability Framework (NES 2009b). It was envisaged that students would cover significant amounts of content in work based learning components. This indicated a need for transparency in the education process so that mentors can provide appropriate support and guidance, and so that students are exposed to similar work based content. The differences between SHCSWs and APs could be more explicit in relation to programme content, capabilities, learning outcomes and SCQF levels 7 and 8.

The capabilities within the clinical assessment portfolio were based on the Capability Framework (NES 2009b) and were specific to SHCSWs and APs in children and young people's health. This could restrict students' transfer to other parts of the health and social care workforce. In particular, it was not clear how relevant the programme would be for social care support workers. It was not a UK-wide recognised programme and so this group of students could be disadvantaged if they wished to change employment.

Phase two: Surveys of programme participants

7. Analysis of the descriptive questionnaire data indicated that at the time of undertaking the course, there were mixed responses within the competence statements, with a need for some development across most of the domains of practice. Thematic areas where participants showed the highest levels of confidence were in partnership working; in identifying and dealing with issues pertaining to harm or abuse; and using their interpersonal skills to effectively communicate with children and young people. Participants reported the lowest levels of confidence in the assessment of holistic needs of children and young people; health promotion; mental health; sexual health; and areas within personal, professional and service development, particularly audit of care and provision of training and support to others under supervision.

A desire to increase knowledge and understanding of children and young people's health and wellbeing was frequently cited as a reason for undertaking the programme; other reasons included a desire to improve skills and career prospects and to access further education. Programme content was generally considered relevant preparation to the SHCSW/AP role, and mentorship was viewed positively by the majority. A number of suggestions for improvements were made in areas such as the organisation of the initial residential study block, preparation of mentors, HEI expectations of students, and protected study time.

Phase three: results of the qualitative study of participants' and stakeholders' experiences of the education programme

8. Programme participants were located in six different Health Boards, and were employed in a range of child health, school and acute paediatric hospital settings; their mentors were generally practitioners who had responsibility for supervising the support worker, and sponsors were senior managers with responsibilities for the services in which the programme participants were employed.

Contribution of the new role to health care settings:

9. Sponsors and managers saw the new roles of SHCSW/AP as potentially allowing development and expansion of current support workers' roles in community paediatric health, school health and acute care settings. However in the Health and Wellbeing in Schools Project demonstration sites (SG 2009), the new role was more specific. The purpose was to contribute to targeting health inequalities and applying new integrated models of practice to facilitate the delivery of preventative and early intervention programmes, in order to improve health outcomes for children and young people (participation in the SHCSW/AP education programme was a condition of employment, and these participants on the programme were funded). The contribution of the role to the skill mix of existing staff was identified by sponsors as important for this project. In School Health, a sponsor who coordinated a school health service cited financial pressures on the service as her rationale for developing the support worker role, and saw it as *'very much a support role doing a lot of work that we'd do anyway, but just being overseen.'* (Sponsor 4). The institution of a generic support worker in the provision of school health was viewed positively. The variation in the types of workplaces and roles described by the participants and stakeholders above indicates that the education programme aimed to prepare SHCSWs and APs for a wide range of acute, school and community/public health settings. However, in the acute service sector, the support worker roles were focused more narrowly on specialist paediatric areas, such as ventilation support and the plaster room. Some concern was noted that in these acute areas, providing access to appropriate practical experiences to meet the education programme requirements was sometimes challenging for mentors.

In general, there was considerable variation in, for example, the number of hours worked by participants, learning opportunities to meet learning outcomes, working alone or working as part of a multi professional team, and the scope of support worker/client relationships.

Applying for the education programme

10. The application process for the education programme appeared fairly straightforward. However the speed of the application process through to acceptance gave some participants little time to prepare for their studies. Even so many considered this a very good opportunity which might not be available in the future, and were keen to participate.

Academic background of participants

- 11.** Participants varied widely in type and level of academic qualifications held and in how recently this experience was obtained (*this is also reported in the phase two survey results*). The majority of participants, irrespective of academic background, appeared to be coping with the demands of the programme. Some participants who did not have academic qualifications struggled with the academic level of the programme whereas others with similar academic histories had apparently been able to cope with the academic requirements. A few participants had not studied since leaving school, with one saying *"...I've never done any studying before either – just at High School and that's the last time I really did anything."* (Participant 11), and another reporting *"...I hadn't done any studying since [1980s] when I sat my higher in school. I didn't go to university which was a big regret of mine. I hadn't written an essay since then."* (Participant 6). In contrast, a number had recently studied courses in child health, or held HNCs. They generally considered recent study to be an advantage, and some sponsors noted that participants they had nominated for the programme were 'ready' for academic study.

Motivation for undertaking programme

- 12.** Programme participants were motivated to undertake the programme for a variety of reasons. Typically, these reasons fell into three broad categories and included; the perceived opportunity to develop or extend their current practice, to gain more in depth knowledge to inform their child health practice, or to gain a qualification whilst working and hopefully to progress to a Band 4 position.

Although personal learning for its own sake was seen as valuable, the advantages of gaining a qualification were also seen in general terms by many participants. Some participants were more specific about the advantages of the qualification. One of the main incentives was to progress up the NHS Careers Framework to a Band 4 position. Some hoped to be able to enter nurse education on completion of level 8 (Diploma).

"I have been told that by doing this course, it's like a stepping stone. Hopefully after doing this course, if there was another course that would lead me on to being...a trained staff nurse – I would probably go on to do something like that." (Participant 14)

Qualification was also seen as providing a way of developing and expanding practice within current roles. The advantage of role development is also referred to by the following participant.

"I was just interested to know about the child health and well being side of things. Something - more of an insight into things instead of doing the same things day in and day out." (Participant 15)

Mentorship of programme participants

- 13.** A key component of the programme was the allocation of a mentor for each participant. Results suggest that the majority of respondents had

positive experiences of mentorship. Several mentors and programme participants commented on access and technical difficulties at the start of the programme, but for the majority, these could be viewed as 'teething problems', and were resolved throughout the duration of the first programme.

- **Preparation and planning for mentorship**

For some mentors, the process for finding out about the programme had been unsatisfactory, particularly in the case of those who were unable to attend the two day orientation residential course at [HEI].

One mentor had not been contacted prior to taking up the role, and another was visited by one of the tutors, but not until after the participant had commenced the programme. Another mentor took the initiative in finding out as much as possible about the programme being undertaken and made it their responsibility to identify expectations around mentorship. One experienced mentor commented "*... I do enjoy having students, and I enjoy the learning process. But this has been difficult because it's not been clearly laid out, what the expectations are*" (Mentor 1). It seemed that many mentors would have liked more information about the course, the learning outcomes, the placement requirements, how these all linked together, and identification of who was responsible for what, but it was acknowledged that on occasion, organisational issues in the local workplace made the whole process more difficult. The processes in place to orientate and prepare mentors were hampered by factors such as annual leave, distance from the HEI, and timing, which prevented some mentors from taking advantage of them.

- **Roles and Responsibilities**

Other mentors were able to access information about the programme, but were unclear about their role, as evidenced by the following mentor; "*we all have a different idea of what our role is*" (Mentor 9). Experiences ranged from total lack of information about the programme, with reliance on the participant for information, to full electronic access to course materials. Meeting other mentors was viewed as valuable for interpreting programme documentation. There was some confusion about the responsibilities of mentors. The HEI expectation was that mentors would focus on the practice experience of programme participants, and some participants and mentors clearly understood this. However, a sponsor noted some mentors regarded their role as supporting the participant in their academic work, in addition to focusing on the practice portfolio. This was evidenced by the actions of some mentors, who also took on the role of academic support for programme participants' written assignments, "*we go over all the written assignments as wel.*" (Mentor 5). In addition, some participants saw it as appropriate to access their mentor for academic support, e.g. for assignment work.

" ...When I did my first two essays, I let her [mentor] read them, and she said fine ... send them ... I said it [third essay] would be delayed because my mentor was on annual leave and she wanted to read it, and I was told by Uni that I shouldn't be bothering my mentor with that.... Well, I thought that was the idea of having a mentor to read over your stuff ...

give a wee bit of guidance. They kind of said, well you're not meant to be bothering your mentor, letting them read your work. She offers guidance, but she doesn't know how far she should be offering the guidance."
(Participant 5)

- **Arranging Placements**

For some mentors, arranging placements for participants was seen as part of their role, but this was not a consistent view. For those mentors who saw it as part of their role, placement allocation had the potential to be problematic, due to a narrow range of available placements and work settings for certain participants.

Contact time with programme participants

14. Proximity of the programme participant to other health professionals could facilitate contact time not only with allocated mentors but also with other health professionals in the absence of an on-site mentor. Mentoring arrangements were often dictated by the particular professional role and workload. Mentors saw contact time with participants as important, and part of their role, *"We have specific time, we do make specific time, and it is part of my role, and I'm expected to do it, so it's within everyone's working day"* (Mentor 4). Mentors saw as sufficient anything ranging from an hour a week, to an hour a fortnight.

Ongoing support for mentors

15. Experience of being a mentor varied greatly among those interviewed, ranging from those who had never mentored before, to others who had extensive experience of mentoring other students, e.g. nursing students. This in turn led to differences in their expectations of support, both from their managers and colleagues, and from the HEI. For some experienced mentors, lack of preparatory documentation was not seen as a problem, yet for others there was an expectation that they would receive similar support and information as they did when mentoring nursing students.

Another factor raised by two mentors that could facilitate the mentoring process was prior knowledge of the participant, and their capabilities, as they were previously employed in the workplace. However, one mentor qualified this by raising concerns about objectivity of judgement.

Although mentoring experience and skills can be seen to be transferable, it was apparent that information and guidance about both the new role and new qualifications were a priority for all concerned.

As the programme commenced, and the participants themselves became more conversant with its requirements, their dependency on the mentor altered accordingly. Participants referred to the support received from mentors and the efforts they made to understand the demands of the programme.

"My mentor is really interested in everything that I've got, and she's always like bring it in, let me see it and I'll have a read through, and if there's anything I can help you with – she's very hands on, and will do as much as she can to help you." (Participant 5)

Processes for students who fail to achieve

- 16.** The issue of the failing academic student was rarely mentioned by mentors possibly because managers had nominated existing members of staff or recommended staff recently appointed to new posts. Arguably managers may have had less knowledge of participants' academic strengths and limitations. One mentor thought that the reporting system for failing SHCSWs was unclear compared to the student nurses' reporting system.

Programme organisation and structure

- 17.** Generally the programme content was meeting sponsors', mentors' and participants' expectations. Participants gave examples of how the content covered was increasing their knowledge and understanding of complex issues such as resilience, culture and diversity, and equality. Many noted the positive effects of gaining new knowledge on role performance, and mentors appeared to view the programme content as relevant when it matched the role of the student in the workplace, it offered breadth of content and was flexible enough to allow in depth exploration of specific issues. Any familiarity with programme material/content tended to be viewed positively by programme participants. The programme was viewed by mentors as generally offering depth of knowledge, however, there was some isolated concern about the breadth of the programme content. Areas where it did not seem to be sufficiently in depth included issues associated with specific client groups, e.g. mental health issues.

Views on the Capability Framework

- 18.** The domains within the Capability Framework (NES 2009b) all seemed appropriate to the participants' role in practice. Some mentors reported that the learning outcomes and the items or competencies within the Capability Framework could be difficult to apply and time consuming to translate to the local practice settings. As the Capability Framework and items/competencies tended to be presented as relatively high order categories, mentors were interpreting and applying these to their setting which could make it difficult to ensure mentors' assessments of practice were consistent. The domains and competencies were appropriate to all aspects of another participant's role as highlighted by the mentor below.

"...[They are good]..I think as we went through them (domains and competencies) in our mid-term interview, it was clear that the path that we had identified for [Participant] while she was based here, she was going to meet those domains, and she's easily fulfilling the competencies. She's literally breezing through them, well I think she is. I think the

competencies are relevant, I think they address all the different areas she is seeing in her day-to-day work here, and in [Place] I would say, I think it's all relevant to what she's doing. In fact, the domains are what we used to identify what her role would be initially, so we looked through that first to see what she would need to achieve, and then set her role accordingly." (Mentor 7)

The nature of the local practice area meant that in some placements, participants had less opportunity to extensively apply their learning about ethnicity/multiculturalism.

Accessing academic support during placement

- 19.** HEI support was in general timely and helpful to participants, some of whom experienced problems with IT access, e-learning resource materials or the *Chatline*. Participants were clear about how to access support.

Academic level of course

- 20.** There was general acceptance that the academic level of the programme was appropriate, although challenging for those who had not studied recently, and that the majority of participants were able to meet the programme requirements.

Residential study blocks

- 21.** Participants were expected to attend the residential study blocks and their employers were asked to fund their travel and accommodation expenses, which for some proved expensive due to geographical distance from the HEI. Sponsors of participants in the *Health & Wellbeing in Schools Demonstration sites* were able to meet these costs from their budgets.

The residential days provided an important opportunity for participants to meet each other, their lecturers, and to be introduced to the university systems, including e-learning. Although very positive about the study blocks, participants had a number of suggestions for improvement, including more input on e learning/computer usage, more focused content in the first block. More specifically, one of the problems identified by participants related to the inclusion of cohort one and two students' combined attendance in the same classroom.

Participants commented that the second residential study block was more useful and better structured than the first block.

Programme delivery methods

- 22.** The blended curriculum comprised designated residential study blocks, e-learning via *Moodle*, access to a *Chatline*, and work based learning. For

participants in remote locations the *Moodle* system offered distinct advantages. Disadvantages related to lack of computer access.

- **Computer literacy**

Some of the participants highlighted their unfamiliarity with computers (one student attempted to write notes during the residential block sessions to help her with accessing the computer when she returned home). One of the sponsors also highlighted the need for programme participants to have academic and IT skills to support their learning and suggested these should be built in to the actual programme.

- **Accessing a computer**

Those programme participants who did not have access to a home computer sought access elsewhere, and in some cases, lack of computer facilities resulted in failure to access some of the recommended resources. Many of the participants were located in shared offices and accessing computer time could be difficult as illustrated by one participant, "*...my only problem is that the office that I'm in, there are three nurses and me and there's only three desks and computer, so it's like musical chairs.*" (Participant 13)

- **Group working and using *chatline***

Participants were encouraged to work with peers either in person or virtually through the online resources. Participants had varying opinions about how useful the *Chatline* resource was to them. In cohort one the small group size limited opportunities for group discussions. One participant was unable to join the *Chatline* discussions due to prior commitments on the set day. Accessing *Chatline* and achieving dialogue with a lecturer was frustrating for one participant. On the other hand, a sponsor acknowledged the value of group support locally where five participants were able to support each other, and another participant enjoyed the social aspect of *Chatline*.

- **Course materials**

The majority of course material was delivered to participants through e-learning, with some additional face to face input during the residential study blocks. Participants reported very positive experiences of course content but accessing electronic sources was time consuming. If participants did not have a home computer, some would access work computers but NHS computer firewalls restricted access to some sites. Some participants stated a preference to work from text books rather than electronic books. Mentors were also positive about the course structure, content and lay out of learning materials. "*Yes, I think they [course materials] are well structured*" (Mentor 8). Another mentor stated that the programme documentation was comprehensive and well aligned to the participant's work role. Mentors would have liked access to *Moodle* (especially in the early part of the programme) and thought it would be useful to be able to read the course material from home as they were too busy to do this at work; some reported spending time trying to gain access. Others had explored gaining access to the HEI website with the lecturer from the HEI.

Practice and university based assessments

- 23.** Many mentors were experienced in mentoring student nurses but without this background further information would have been required relating to *"...the assessment procedure, the placement assessment. If I didn't have any of that [student nurse assessment] experience that would be something I would probably need help with."* (Mentor 3)

Mentors recognised that when the programme participant was well known to them, objectivity in practice-based assessment could be a problem. The alignment of practice based learning experience with learning outcomes relied on the provision of appropriate role tasks/activities and a breadth of working practices (not always available to those programme participants in the acute sector).

In reference to the written assignments participants' found the word limits restrictive (also noted by a sponsor). However, participants described their satisfaction when they received assignment feedback.

Protected study time

- 24.** Access to study time was considered important by some mentors. Within the placement agreement between the HEI and placement there was an expectation that students would have a study day per week (pro-rata). There was variation in the study time participants reported, ranging from those who were granted the agreed time, through to those who had none. A participant who did not get study time stated that she did the academic work when she was on night duty or on days off. *"...We've got to do it at nights or on our days off sort of thing."* (Participant 15) Another stated, *"No, I do it [study] all from home I don't have time at work to do it – I do it all from home."* (Participant 2) And similarly, participant 11 noted that *"I certainly haven't been given time."*

In one case the allocation of study time was monitored by the HEI lecturer.

Participants recognised the value of protected study time in addition to the work they undertook in their own time, as did some sponsors.

Perceived impact of programme on performance

- 25.**
- **Personal and professional development**

Mentors and participants were able to identify and consider a number of positive developments in participants' performance. These often related to growth in the participant's self-confidence, and contributed to advancing the self-development of the practitioner.

- **Role development**

There was also some recognition that the programme had given participants an opportunity to consolidate their work-based learning and academic development. General comments from participants and stakeholders illustrated that participants were addressing gaps in their knowledge, consolidating experience and gaining confidence. Some participants were discovering theory they could relate to their former and existing practice, gaining a better understanding of *'why things are done'* and stakeholders noted the potential of the programme to empower the student to develop new psychomotor and leadership skills, as well as career progression. Additionally, some participants were noted to practice more independently. In contrast to the majority, one participant highlighted the limitations of undertaking the programme when practice opportunities were restricted, as in the case where practice was focused on the care of one child, and some stakeholders thought it was too early in the programme to note any specific advances or developments in the progress of the participant.

The future workforce and participants' career plans

26. This theme encompasses organisational perspectives on the future of SHCSW and AP roles and participants' personal career aspirations.

- **Organisational perspectives on the future of SHSW and AP roles**

There was general recognition of the need for SHCSWs and APs to be included in the future healthcare workforce. Whilst some mentors had concerns about introducing another level of staff, they were positive about the abilities of individuals with whom they had worked. There was also recognition that individuals who did not have health care experience could take on these roles with appropriate preparation. However, concerns were raised about overloading the participant with delegated tasks or indeed not using them to their full potential.

Support workers in the demonstrations sites faced an uncertain future, but their mentors hoped that they would continue to have posts at the end of the project.

In some cases there was a perception that greater preparation of the wider team was required. From a participant's perspective there may be tensions within teams related to the scope of the new roles.

"so there is kind of a feeling on one half that this is something that is going to be brought in, kind of like a health visitor assistant and on the other side they say that's like taking away skills because we don't have a nursing background to move into that direction, people are saying that we're coming in the back door and taking away the nice jobs. So there's a lot of issues with other health professionals about the role."
(Participant 11)

Fear of financial constraint as a limit to the numbers of people appointed to healthcare support worker roles and the numbers of qualified staff providing

supervision were voiced by some stakeholders. There were some concerns that participants in generic therapy support roles may not be able to progress beyond their current role. A sponsor was unsure how employers would assimilate the different bands into their organisation's workforce.

Despite these uncertainties, generally sponsors were optimistic that SHCSW and AP roles would form part of the healthcare team in the future. A sponsor in acute care referred to definite plans to increase Band 4 posts within the organisation and so completion of the programme would contribute to this objective.

- **Participants' personal career aspirations**

Participants understood that successful completion of the programme did not automatically mean they would be promoted to a Band 4 post and some believed that nurse training was the next logical career step for them. Due to uncertainty surrounding their future job, some were considering options for further education in disciplines such as nursing and social work. Another participant was undecided about her future but had a positive attitude to remaining in post. The uncertainty about future roles was particularly acute for participants on fixed term contracts in the Health & Wellbeing project demonstration sites. An additional concern of these participants was that:

"The actual contract for the job will finish before the course is due to finish but I think that there are arrangements in place that we will be able to complete the course even if the job doesn't continue." (Participant 3)

Overall evaluation of programme

- 27.** A range of positive experiences were reported by stakeholders and participants, for example *"... I think the programme's very good"* (Participant 13) and that it was a very good preparation for working with families. The extent to which the programme met the learning needs and expectations of participants is illustrated below.

"...It's meeting the needs of what I want to learn and is going to help me get down the career path that I want to go and working with families is excellent; the broad spectrum. There's a lot of work involved without a doubt – a lot of reading – but it's a very good course I've got to say for giving you the knowledge and the experience for working with families." (Participant 6)

Programme design and content were deemed satisfactory, and the learning was perceived to be useful both for present roles and future careers. Some programme participants were aware that the impact of their roles would be evaluated. As previously noted by stakeholders and participants, the programme has had a positive impact on role performance and development, both in terms of the participants' self-development, confidence and independence as well as increased knowledge and application of theory to practice.

Less positive comments were made about the organisational aspects of the programme, such as accessibility of materials within the introductory two day residential block, the length of the initial block, mentorship support and preparation, and the restricted scope of some practitioners' practice placements. The majority of the problems associated with these elements can be regarded as 'teething' problems associated with new programmes, and to the speed of development and launch.

Preparation of mentors was patchy for the first cohort but seemed to be perceived more positively for the second. In view of the large responsibilities placed on mentors with regards to programme content in the work based learning mode of delivery, the preparation of mentors is therefore crucial.

A further limitation highlighted by certain participants to be overcome for future intakes was the variation in placement experiences during the programme as this impacted on ability to complete learning outcomes.

Discussion of evaluation findings

28. Aim 1: To evaluate the outcomes of the education programme in relation to the five key domains of practice

The phase two results indicated that participants perceived they were less confident in theme four, care and intervention, and in theme five, personal, professional and service development, particularly audit training and support of others. Limited data from those who completed two surveys suggests an increased confidence across the competences over time.

Within phase three, the participants and mentors had generally found the *Clinical Assessment Profiles* (which were based on the NES Capability Framework) helpful. There was evidence of developing capabilities but some participants had real practical difficulties meeting the learning outcomes and practice capabilities due to the nature of the workplace setting. Mentors helped the participants to interpret the capabilities for the local context, but this could potentially result in some inconsistencies between mentors' assessments; however, this is a feature of many clinical assessment tools which are not developed through rigorous empirical techniques. A further issue relates to how realistic it would be to expect students to achieve all performance outcomes in both placements at each SCQF academic level.

The breadth of programme content and blended curriculum were generally well received, the online course materials were noted to be of high quality, and the formative assessment processes for academic work were commended. The opportunity provided to explore topics to the required analytical level of university education may have been limited by the brevity of assignment components and the small word counts.

29. Aim 2: To evaluate the appropriateness of the education programme for SHCSW and AP roles

This academically diverse group would have created different demands for academic support. However the majority appeared to be coping well with academic work and positively evaluated programme delivery methods, mentorship, course content and learning material.

There were some suggestions in the data that the self-assessment of learning needs formed the basis for future support in the programme. It is questionable how accurately students, many of whom had been out of education for some time, could interpret their learning needs. An example would be in the assessment of computer literacy and the differences between domestic use and accessing computers for e-learning. Nevertheless, data indicated a growth in self confidence which is reflected in increasing appreciation of the programme as they progressed.

Protected study time was considered very important, but the amount allocated to participants varied considerably which could reflect a tension between demands of service delivery and educational development.

The degree of fit between the education programme and the SHCSW/AP roles was influenced by the work based learning setting and the experiences offered. In narrowly focused placements, such as specialist departments within acute areas, it may be difficult for students to meet some capabilities.

The *learning community* envisaged by the HEI pre-supposes that everybody concerned with the programme would have access to all media to encourage reflective dialogue. This ideal needs to be promoted in induction information, preparation of mentors, guidance to students and in provision of accessible computer resources.

30. Aim 3: To explore the impact of new roles on individuals and service generally

From the outset the majority of participants in phase two reported clear views on how the programme was equipping them to work with children and young people, by developing their knowledge and understanding, and preparing them for greater role responsibility. Many could identify opportunities for career progression and these views were reflected in phase three data where they also reported increased self-confidence and feelings of empowerment.

31. Aim 4: Identify current career aspirations upon completion of programme.

Within phase two, many reported it was too early to predict future employment, however some had already noted the potential for improved career prospects. In phase three, participants articulated career aspirations to enter band 4 and higher education including nursing degrees. However

stakeholders and participants were sanguine about such career prospects given the current financial climate.

There were some concerns about the potential impact of these new roles on existing teams; for instance, the possible changes in the ratio of registered to unregistered staff, and the re-allocation of activities perceived to be rewarding to registered staff. Arguably this may further result in exposing registered staff to an increased concentration of stressful caseloads and could lead to an increasing need for staff support.

Main conclusions

32. This education programme offers a blended, flexible and accessible curriculum that integrates work based learning, learning and teaching delivered through residential study blocks and e-learning technologies. Mentors in practice have a crucial role in supporting, educating, motivating and assessing students in practice, and students' academic development is facilitated by an experienced education delivery team and high quality university library and support services. The contemporary e-learning programme materials meet the requirements of the participants. The implementation of the education programme represents a successful collaboration between academic and placement settings, and NES, that can continue to be developed through the ongoing analysis of feedback from students, academic and placement staff. The programme augments skill mix in health care teams by developing individuals who can contribute to the health and wellbeing of children, young people and their families, thus meeting current government policy drivers.

As this was a new programme with the added complexities of serving a geographically dispersed student population with a variable history of accessing higher education, it could be expected that there would be some problems during implementation. The tight time-frame for introducing the new programme reduced opportunities for thorough preparation of mentors in all settings, the identification and planning of work based learning opportunities was sometimes incomplete, and improved preparation of health care teams may reduce ambivalence towards new roles in some areas, as the current initiative also represents a substantial cultural shift for the NHS by focusing on non registered SHCSW/AP practitioners as an integral part of the workforce. It is unfortunate that new SHCSWs/APs will be anticipating career progression at a time of political and economic uncertainty.

Recommendations

33.

- Clearly identify the student support mechanisms available to students

Instructions on how to access the *Centre for Student Access* are included in the *Student and Mentor Handbook* (RGU 2009) but students new to higher education may not be familiar with the services available there. Some students may not be aware that they have specific learning needs at the start

of the programme and so the effective learning service should be promoted to all participants.

- Pre-programme academic study skills

If the programme is extended to larger student intakes and/or more HEIs, it may be necessary to provide access to pre-programme academic study skills. This could include library skills, computer/IT skills, online learning, and academic writing. Procedures for self assessment of learning needs may need review.

- Clearer demonstration of how the curriculum fosters the development of generic cognitive skills such as critical analysis, and evaluation of ideas, concepts and issues at SCQF level 8

Currently generic cognitive skills do not appear to be articulated in the learning outcomes for modules and therefore written assignments assume a specific importance for demonstrating these elements. Learning activities and written assignments are of great importance for the development of generic cognitive skills within distance learning but the evaluation team did not have access to the full range of learning activities to be able to make more specific recommendations.

- Maintain and develop the education programme's peer assessment strategy

A particular strength of this programme is the intention to use peer assessment in line with the goal of fostering a *learning community*. Peer interaction indeed can enrich learning outcomes and make learning more interesting and allow elaboration of content (Biggs 2003).

- Future evaluation of the impact of the programme on roles and integration into teams

Evaluate impact of programme on students' practice one year on, to focus on their role development and integration into the team following completion of programme, and to investigate their role in the delivery of planned interventions in children and young people's health and their work with families.

- HEI should monitor adherence to the *placement agreement plan* with placement managers

The HEI in conjunction with placement managers should monitor the implementation of the *Placement Agreement Plan* with reference to students' work based learning experiences, mentorship and protected study time to ensure equity of student experience. For instance, some managers may require 'back-fill' for posts where students need alternative experiences to maximise learning opportunities.

- Maximise the use of learning activities during residential study blocks

Participants in phase three reported 'hands on' activities and group work were very effective for learning within the residential blocks. They also recommended that different cohorts recognised the value of meeting students in other cohorts but this could be more effective in an informal social event rather than in joint classroom sessions.

- Review the processes for disseminating information to prepare and support mentors

Few mentors were able to attend the mentors' session on day two of the initial study block and not all had received a copy of the *Student and Mentor Handbook*. The programme team should consider additional methods for disseminating programme requirements and their expectations of mentors such as through an online *Mentor Centre* and/or a *Helpline*. A separate *Mentor Handbook* (in addition to a *Student & Mentor Handbook*) may be required.

Contact time with the mentor will be contingent on the location of the student and where the mentor is based in a different location, this needs to be factored in to planning.

- Consistency of assessments should continue to be monitored

A consistent approach to assessment in practice and across contexts of care should continue to be addressed through the preparation and ongoing support of mentors.

- Clarification of expected levels of performance at SCQF levels 7 and 8 and within the capabilities

The programme delivery team should review and clarify the expected level of performance within the capabilities in the Capabilities Framework and according to SCQF levels 7 and 8 to emphasise the differentiation between these levels. The current heavy emphasis on cognitive components of capabilities rather than effective and affective performance of interventions may require some adjustment. Mentors also require in depth knowledge of the theoretical components of the programme due to the emphasis in the *Clinical Assessment Profile* capabilities on the demonstration of knowledge and understanding of underpinning theory. In line with quality assurance processes the *Clinical Assessment Tool* should be evaluated by mentors.

- The pass/fail criteria may require further discussion.

It is implied that students must achieve all outcomes in the *Clinical Assessment Profile* to be deemed 'satisfactory and safe', but this should be made explicit in the documentation. Mentors could find it difficult to provide an accurate assessment if the fail criteria/ performance criteria are not explicit.

'Cause for Concern' processes are articulated in the guidance for clinical documents which are available online (May 2009) but do not appear to be included in the *Student & Mentor Handbook*. Moreover, the cause for concern

processes are viewed as a joint responsibility between the HEI and the Employer.

'To withdraw from the placement any student whose health, behaviour or action is deemed to jeopardise patients' welfare or otherwise seriously impair the placement's operations. Initiation of such action shall be immediately reported to the university' (RGU 2009 p 4).

However the role of the mentor in the 'cause for concern' process again does not appear to be explicit.

- Highlight the HEI expectations of students prior to admission

Whilst the university and specific programme entry criteria are clear, the self assessment of perceived computer literacy and access to a computer may require review. Students need to have access to sufficient information about the academic and practice expectations to make an informed decision about their participation.

In addition:

- The possible future expansion of this programme to other healthcare settings may require precise definitions of core and specific practice capabilities acknowledging that some capabilities may be locally determined by the requirements of different healthcare settings.
- In relation to widespread implementation of the programme as currently designed, some consideration will need to be given to curricular content in areas such as physiology, data handling (including numeracy), analysing evidence, theories of teaching and learning, and audit.

SECTION 1: Introduction to the evaluation

1.0 Background to the evaluation

This report provides an evaluation of an education programme for Senior Healthcare Support Workers (SHCSWs) (SCQF Level 7) and Assistant Practitioners (APs) (SCQF Level 8) for Children and Young People's Health (CYPH) with optional pathways at a Scottish Higher Education Institution (HEI). The evaluation was commissioned by NHS Education for Scotland (NES), undertaken by a team from the School of Health Sciences at Queen Margaret University Edinburgh, and carried out over 12 months from June 2009 to June 2010.

Several policy documents produced in recent years (SEHD 2005, 2006a, 2006b, 2007; SE 2006a, SE 2006b) emphasise the need for new service delivery models and an integrated team approach to care to respond to policy and practice drivers. Health and Social Care Support Workers have provided a dedicated and valuable service over many years. The shift in services to the community setting has resulted in the expansion of the Health and Social Care Support Worker role and responsibility. Many health and social care workers, although experienced in the delivery of care have in the past been unable to access academic opportunities. This lack of opportunity to attend programmes, coupled with economic and social factors, may have disadvantaged this group of staff in their pursuit of higher education which is now essential in the light of changing demands in this diverse workforce.

To support children and young people in the context of a changing workforce and services, the development of educational strategies and programmes is required in order to provide appropriate and relevant education for health and social care teams (SE 2006a, SE 2006b, SEHD 2007, SG 2008a). In particular, increasing acknowledgement of the potential role of the health care support worker within nursing and allied health professional teams requires educational programmes to provide an holistic and blended approach to learning that relates theory to practice, and ensures that this group of staff feel supported and have the necessary skills and competencies to work in teams in a variety of health and social care settings. This educational initiative therefore is timely and crucial, as is the evaluation of its process, outcome and overall success.

1.1 Aims and objectives of the evaluation

NES specified the aims and objectives for the evaluation of the programme and later modified these as shown below.

The original aims were to:

- Evaluate the outcomes of the [education programme] in relation to the 5 key domains of practice
- Evaluate the appropriateness of academic level (SCQF Level 7 & 8) for the SHCSW & AP roles
- Evaluate the impact of the new roles on the individual, the children, their families and services

- Identify employment patterns following completion of programme

The modified aims identified by the NHS Education Scotland Steering Group in June 2009 were to:

- Evaluate the outcomes of the above education in relation to the 5 key domains of practice
- Evaluate the appropriateness of the education for the SHCSW & AP roles
- Evaluate the impact of the new roles on the individual and services
- Identify current employment aspirations for completion of the programme

Objectives

1. To collect, analyse and report back on the numbers, types and location of students who have undergone the education for Senior Healthcare Support Workers and Assistant Practitioners in Children and Young People's Health and/or who have used the agreed Capability Framework to plan required learning.
2. To collect, analyse and report on the content and approaches to delivery and costs of the education provision.
3. To collect and analyse feedback and report on findings of the experiences of individuals.

1.2 The evaluation design/methodology

A mixed methods evaluation approach was implemented. The evaluation consisted of three phases with the first phase drawing on existing programme data across the time span of the programme, the second phase focused on survey data collected from the programme participants, and the third phase comprised a qualitative telephone interview study with programme participants and stakeholders (mentors and sponsors) to explore experiences of the programme.

Phases in the evaluation

1. A scoping study of programme documentation and ongoing analysis of programme data was undertaken to establish the context in which the programme is being delivered, the characteristics of the planned programme, the actual programme delivered, baseline and outcome data relating to participants.
2. Surveys of programme participants collected data on demographics, current post, reasons for undertaking the programme, perceived levels of confidence and competence in the five domains of the draft capability framework, academic background, academic level of the programme, and employment patterns.
3. A qualitative interview study of participants and stakeholders captured participants' experiences of the programme and explored the nature and perceived impact of the new roles on individuals and services (see pages 62 - 119).

1.2.1 Phase 1: Scoping study of contextual location of the programme, the programme documentation, and baseline data on programme participants

Contextual location of the programme

This evaluation report presents a description of the context within which the programme was being delivered gained from documentary evidence collected by the evaluation team, from the programme team, on the initial site visits.

Programme documentation

These data document the planned programme and the programme as implemented, and comprise the education programme design, module array, learning outcomes, methods of delivery, teaching teams, assessment strategies and costs of the programme.

Programme participants

Routine data collected on programme participants at the start of the programme included demographic information such as name, employer, and current post, but further data on age, gender, ethnic group, academic and professional qualifications and the first part of post code were obtained from questionnaire responses in phase two. Participants were informed by the education delivery team that the programme was being independently evaluated and that they would be invited to participate.

1.2.2 Phase 2: Survey and repeat survey of programme participants

A descriptive survey of programme participants at the start of the programme provided demographic information, details of current post, reasons for undertaking the programme, recruitment to the programme, employment history, academic background, perceived confidence and competence in the five domains of practice (from the NES Capability Framework) and their sources of information about the programme. A repeat survey during the programme added the items of change to their role, and if this was as a result of the programme, the academic level of the programme and their experiences. The questionnaires contained fixed response and some open response items. Data collected in the surveys were used to identify potential participants for the qualitative interview study.

1.2.3 Phase 3: Qualitative interview study of participants' and stakeholders' experiences of the programme

A volunteer sample of programme participants, their mentors and sponsors (senior managers) were invited to participate in a qualitative semi structured interview study (15 participants and 17 stakeholders). The purpose of the qualitative study was to gain rich data on participants' and stakeholders' experiences of the programme, what had worked well or had not worked well for them, what they had gained or not gained as a result of completing the programme, the nature of their current roles, the impact the programme had on their confidence and competence across the five domains, the implications for the service, and the academic level of the programme. Data were collected by telephone interview using a schedule with the topic areas

identified in advance. The informed consent of participants was elicited before the interview commenced, permission to tape record the interview was gained and their consent to use interview data was re-affirmed at the conclusion of the interview.

1.3 Data analysis strategies

The data were analysed in the following ways. Programme documentation underwent documentary analysis to examine the substantive content and to compare the planned programme with the one implemented. Data on the programme participants were anonymised and entered into summary tables. Survey data underwent descriptive statistical analysis using Excel and descriptive codes were applied to open responses. Qualitative interview data were transcribed, an initial coding framework was developed and the transcripts were imported into an NVIVO 8 database. At this stage, line by line coding of data was undertaken and themes and sub-themes were identified.

1.4 Ethics approval process

As the potential research participants were members of NHS staff, the principal investigator consulted NHS Research Ethics and Research Governance. The current study did not propose to include children or their families as research participants, and focused on the opinions/views of staff. The principal investigator was duly informed that full NHS ethics approval and research governance approval were not required beyond noting that the study was taking place, as the researcher had done. The study was subsequently submitted to QMU research ethics and RGU research ethics committees and approval to proceed confirmed in August 2009.

Potential research participants were invited by the research team to participate in the study at an initial face to face meeting during a combined cohort one and cohort two residential study block, at the host HEI, in September 2009. Questionnaire packs included a participant information sheet (Appendix 1) detailing the purposes of the study and what would be involved if they decided to participate, a self completion questionnaire (Appendix 2), two copies of the consent form (Appendix 3), which they were asked to sign and return to the principal investigator with their completed questionnaires, and a SAE. The information sheet intended to provide sufficient detail to enable participants to decide on their participation or not, and to be able to give their fully informed consent if they decided to participate. The privacy and confidentiality of potential research participants was respected during recruitment, data collection, data analysis and in this final report.

The research team approached potential research participants for phase three of the study by email or by phone using the contact information provided in postal questionnaire returns. They were asked to provide contact details for the mentor and senior manager (sponsors for students undertaking the education programme). Researchers arranged interviews at a time and place

convenient to the research participants. All data were stored in a password protected secure computer system in a project folder only accessible to members of the research team and subject to the QMU Policy on the secure storage and disposal of research data. During data analysis, codes were used to protect the anonymity and confidentiality of research participants. There are potential threats to the anonymity and confidentiality of research participants in studies where the population is small and membership is visible to a wider audience, as in this case of programme participants on a national programme. For this reason identifiable locations/services have been anonymised in the results reported, and linkages between programme participants, mentors and sponsors are not stated.

1.5 Strengths and limitations of the evaluation design

A mixed methods evaluation design comprising three separate phases was undertaken. The evaluation team visited the research site in July and September 2009 to collect documentation and information for phase one of the evaluation. The team met with the programme leader and were given access to the programme documentation. Limitations of phase one are that the evaluation team did not have access to *Campus Moodle* or information about students' individual programme performance other than receiving verbal reports from the delivery team that all students had to date passed their summative assignments.

Programme participants were invited to participate in phase two of the evaluation project by returning the first of two self-completion questionnaires and by indicating if they might consider participating in phase three of the evaluation. The descriptive questionnaires reported participants' perceptions of the education programme, general background information and contact details for phase three. Assurances were given about confidentiality and anonymity if participants chose to participate in the evaluation. As noted above linkages between participants, mentors and sponsors are not reported to protect the identity and anonymity of research participants. The response rate to the first survey was 62.5% (n=20) which is in line with general response rate expectations, but the responses to survey two were disappointing (n=6). Further limitations included the need to distribute second mail-shots for both surveys that aimed to increase the overall response rates. The evaluation team did not have access to a list of students' contact details and so the education delivery team were asked to address and mail questionnaire packs to participants. The education delivery team also posted survey response reminders from the evaluation team on *Campus Moodle* (a virtual learning environment within the HEI), on several occasions at the request of the evaluation team. It is possible that the length of the postal questionnaire which addressed all elements of the Capability Framework (NES 2009b) may have discouraged some participants from responding. The relatively small population may also have reduced responses as participants may have thought they could be identified.

The participants who volunteered to take part in phase three mainly comprised those who had returned their postal questionnaires in phase two and indicated they may be interested in participating further. Two further

participants were identified through sponsors (senior managers), but in all cases informed consent was obtained prior to interviews and confirmed at the conclusion to interviews. This study is limited by the volunteer sampling method used which could have omitted other opinions. The interviews were conducted by a number of members of the research team but potential variations in approach were minimised by the use of an interview topic guide, independent transcription of interviews and team discussions during data analysis. The views expressed relate to a small sample of the overall population of students, mentors and sponsors involved in the programme, rely on the accuracy of their self reports, and are limited by the absence of observational data which would have been impractical to obtain for this geographically dispersed population.

Section 2: Literature review on the education and development of senior healthcare support worker and assistant practitioner roles

2.0 Introduction and literature search history

A narrative review was undertaken including a focused search of the literature reviewing the educational needs of senior healthcare support workers and assistant practitioners and the development of their roles encompassing the period between 1998–2009. Key terms used were 'assistant practitioner', 'healthcare support workers', 'skill mix', 'educational needs', 'role development' and the following databases were searched: EBSCO (including CINAHL), Cochrane, EMBASE, SCOPUS and ASSIA. Current government policy documents were included to provide the context to the review. For the literature found, inclusion criteria included peer reviewed journals dating from 1998 to the present, journals written in English and that were accessible and research findings that were published.

2.1 The policy context

At this time nationally there is a move from the acute sector to community based services, providing care that is focused around individuals and their families and carers in their homes with a change from an illness based approach to one of health improvement, preventing ill health and reducing inequalities (SEHD 2005, 2007; SG 2007, 2008a). Other policy drivers impacting on care are the demographics of an ageing population, the changing age profile of practitioners and a decreasing number of people of working age with the potential challenge of a reduced workforce in its current form (Buchan et al. 2008; Buchan & O'May 2009; SEHD 2006a, 2006b).

To support the changing service provision and the demands in health and social care, there is an opportunity for health and social care professionals to re-evaluate the way they work, particularly in terms of the development of multi-disciplinary and interagency teams providing care and working in partnership with progressively more diverse communities (SEHD 2006a; 2006b). Working together is seen as a vital component in offering the highest possible quality of service that is open, accountable, accessible and responsive. A flexible, interdisciplinary and collaborative approach is required to make the best use of skills and resources, changing both the focus and the strategies utilised, and promoting new ways of working (Peckham & Exworthy 2003). Due to the ageing population and community based care there is a growing demand for an increase in the health and social care workforce to meet the needs of older people and the provision of anticipatory care and care for long term conditions (SEHD 2006a). This in turn puts pressure on the current health and social care workforce who work with children and young people, both in hospital and community based teams, with an anticipated rise in demand for non-registered staff (SE 2006b; Buchan 2008).

The issues that affect children and young people appear increasingly complex and include issues of vulnerability, social exclusion and deprivation, lifestyle choices, the changing face of 'the family' and specific health issues relating to complex needs, mental health, sexual health, and end of life care (SE 2005,

2006a, 2006b; SG 2007; 2008a). From a public health perspective in terms of children and young people's health and well-being there is a need to ensure that there are safeguards in place to support and protect children and young people through the different transitions that take place during childhood and adolescence (SE 2005; SEHD 2005). By strengthening the capacity within families and communities to respond to the needs of children and young people the health and well-being, physically, emotionally and socially of the next generation will be fostered (SE 2006a; SEHD 2006b). These connect not just to illness and disease but also to the life circumstances relating to health, social, and educational care including factors such as environment and economic issues within the context of their families, social groups and the wider community (Hall & Elliman 2003; SG 2007).

Several policy documents have been produced in the last five years (SEHD 2005, 2006a, 2006b, 2007; SE 2006a, 2006b). All emphasise the need for new service delivery models and an integrated team approach to care to respond to policy and practice drivers and the changing demands in the health workforce (Buchan & Seccombe 2005). To support children and young people and their families in tandem with the changes in the workforce and service delivery models, it is recognised that there is a need to develop a highly skilled workforce (SE 2006b; SG 2008b). In order to facilitate this, there needs to be the development of educational strategies and programmes that will provide appropriate and relevant education for health and social care teams (SE 2006a, 2006b; SEHD 2007; SG 2008a).

In particular, the increasing acknowledgement of the role of HCSW, senior health care support worker (SHCSW) and assistant practitioner (AP) within nursing and allied health professional teams (NES 2009a; Robinson et al. 2009) requires educational programmes that provide congruence between what is learned in theory and applied in practice with a programme that is grounded in the context work based learning, integrating theory and situated learning experiences (Wigens 2006). Educational programmes need to address barriers to progression in work and life long learning and provides a clear career structure within which roles can be developed. This is central to Agenda for Change and the Knowledge and Skills Framework (DH 2004). With non-registered nursing posts at Band 3 and 4 becoming increasingly significant (Robinson et al. 2009) it is thought essential to provide access to higher education in keeping with the philosophy of 'Lifelong Learning' (SE 2003). The educational requirements of SHCSWs and APs in terms of working with children and young people in relation to their health and social care needs should be at Scottish Credit and Qualifications Framework (SCQF) Level 7 and 8 (NES 2009b). There is an expectation that this workforce should be offered opportunities to gain relevant qualifications and this in turn will enhance the status and value of a significant workforce (SEHD 2006b; SG 2008b).

2.2 Skill mix within the workforce

In terms of the current challenges facing healthcare providers in the current economic situation with the additional demands for high quality care and

increasing staff shortages there has been a growing debate in the nursing profession around the increase in use of support staff or skill mix (Lankshear et al. 2005). The majority of studies found relate to workforce and patient outcomes in adult nursing in acute care and residential care settings with the majority of the literature being located mainly in the USA and being dependant of specific workplace contexts (Buchan & Dal Poz 2002; Robinson et al. 2009).

In terms of support workers the literature available mainly related to working with adults. A study relating to grade or skill mix in district nursing teams in Scotland focused on the skills required within the team (McIntosh et al. 2000). This study took an ethnographic approach to explore skill requirement in teams where grade of staff included Grade B to G and delegation practice within teams in two geographic areas with a sample size of 76 participants. Participants were interviewed pre and post an observed session in practice. The main findings were that nursing auxiliaries (Grade B) were supervised by Grade G district nursing sisters who would either directly supervise care, engage in follow up visits to patients and through discussion of care provided with nursing auxiliaries. The district nursing sisters would assess the workload and base this and their assessment of team skills on how delegation of workload took place. An additional aspect noted in the study was the necessity for staff development and relevant experiences in practice to develop and have access to training and educational opportunities. The paper concluded by noting that if there was to be 'further dilution' of skill mix that the leadership and supervision provided by the G Grade sister should be acknowledged. Since this study took place there have likely to have been significant changes in the community nursing workforce.

The themes of delegation and supervision were noted by Orne et al. (1998) in their study in the United States of America explored nurses experiences with unlicensed assistive personnel (UAP) in the hospital setting. This phenomenological study had a sample size of twelve participants working in acute care environments with a range of experience as registered nurses from six to thirty years. The method used was unstructured interviews with thematic analysis and the development of theme clusters. Main findings from the study was that opinion was mixed with acknowledgement of organisational change and financial demands on the service and the experience of participants when delegating tasks and their concerns regarding the abilities of the UAPs and their own in skills of delegation. Participants noted that the UAPs at times had an unrealistic viewpoint as to their role and their wish to have a greater responsibility than the registered nurse perceived them ready for. Themes identified within the study included "Compromised Care/Patient Safety and Professional Risks and Fears" (Orne et al. 1998, p. 107). In addition, the lack of preparation of the registered nurses in how to manage a change in skill mix within the team was also highlighted. Due to the methodological approach the sample size was small and could be seen as not fully representing registered nurses views in general.

There was minimal literature available relating to SHCSW and APs working in the context of children and young people's health and social care. An evaluation of a Sure Start project in Wales looked at the role of health

support workers who worked with Sure Start health visitors (Smith et al. 2007). The project employed HSWs who were supervised by health visitors. This was identified as a means to support health visitors in terms caseload management and public health aspects of their role (Ebeid 2000). The study aimed to evaluate how appropriate and effective the services provided by HSWs were through realistic evaluation. HSWs, health visitors and service users took part in focus groups followed by semi structured interviews of selected service users. The themes from the content analysis of the data identified the context as being meaningful, in this case area with a high level of deprivation and the challenges this presented. Education or training of HSWs was also identified as another key theme as necessary "*in order to improve confidence in the service ...issue of support and supervision and awareness of safe working practice,*" (Smith et al. 2007, p.34). In addition the HSW appeared to play a valuable role in a seamless service provision from a service user perspective. Issues such as career progression and levels of pay were noted with recognition that the participant numbers and size of the evaluation were small highlighting the need for future studies. The issue of career progression for support workers was also noted by Griffin et al. (2010) in midwifery services with a need for educational provision to support this role development.

2.3 Educational needs

While educational support for support workers has been highlighted in different studies and reports there was limited literature found and was mainly related to evaluation of training and programmes for health care support workers equivalent to SCQF Level 6 & 7 (Buchan & Dal Poz 2002; Jardine & Wallis 1998; Smith et al. 2007). It has been identified nationally that there is a need to provide opportunities for training and development for HCSWs in line with the Knowledge and Skills Framework (SEHD 2006b, NES 2009a). Traditionally in Britain the emphasis has been on in-house training within the organisation or level 3 National Vocational Qualifications (NVQ) or Scottish Vocational Qualifications (SVQs). Moseley et al. (2007), in their survey of HCSWs and their managers, utilising a self-report questionnaire of 117 participants, found that there was close agreement between HCSWs and their managers as to the training needs requirement. Their findings were related to the KSF descriptors and while communication skills and other elements of 'care' were noted, the main areas where challenge to their training needs were identified, was in biomedical and physiological knowledge and data handling in terms of competencies. This highlighted the changing and increasing complexity of care provision and evidence based practice with the need for significant changes in training and educational approaches to respond to these factors.

In terms of the AP, while this role is seen as increasing both in numbers and range of practice (Spilsbury et al. 2009) the literature relating to role development, education needs and career progression was difficult to find. Spilsbury et al. (2009) found in their service evaluation across England that there was a disparity in opinion regarding the AP role in comparison to Band 2 and 3 HCSWs role. However some directors of nursing recognised this role as a means of career progression for non-registered staff. It was noted in

terms of educational needs that some Trusts worked with local universities to look at accredited foundation degree courses or higher education certificates while others did not appear to have this approach in place. An inconsistency in terms of education provision and a concern relating to this regarding transferability and career progression for APs was noted in line with the need to recognise regulation of the role in terms of public protection.

This inconsistency was identified in a study looking at clinical managers' views of midwifery support worker (MSW) roles (working at bands 2 - 4) in London. It was found that there was a range of training and educational opportunities that varied between trusts with an overall agreement between participants that the disparity created challenges in career progression and transferability (Griffin et al. 2009). A programme specifically related to the needs of MSWs was one of the findings from the study with key areas of focus being communication skills, classroom and practice based learning opportunities and introduction to the wider context of the maternity team.

This was echoed in an evaluation of a course for HCSWs working with children with complex needs and their families in the community setting (Hewitt-Taylor 2005). Relevance of theory to the practice context was seen as key with acknowledgement that staff working in children with complex needs needed opportunities to develop their knowledge and skills in this specialist area. The evaluation of the course included method of delivery as this was a distance learning course of study. Materials were provided as text based rather than web-based options and these were evaluated positively by students. Work based learning and assessment were incorporated in this approach for students equivalent to NVQ 2-3. Galloway and Smith (2005) in a discussion paper of a course for support workers in rehabilitation found similar themes developed when evaluating the course in terms of work-based learning and relevant visits in practice to meet learning outcomes.

Work based learning approaches for pre and post registration nursing have been identified as addressing the needs of practitioners in matching the requirements of a rapidly changing health service and developing nursing practice (Clarke & Copeland 2003) by promoting learning that is practice driven (Walker & Dewar 2000). This approach for education programmes for HCSWs would appear to complement existing approaches to facilitating learning that is context relevant. Key to work-based learning approaches is the support and supervision of students in the practice context (Wigens 2006). A challenge to the delivery of this approach to learning for SHCSWs and APs was highlighted in a discussion paper examining the educational and organisational issues relating to the development of mental health assistant practitioners (Warne & McAndrew 2004) and the acknowledgement in the paper that qualified mental health nurses were already under increasing pressure in terms of mentoring, supervision and facilitating learning experiences for pre and post registration nurses in line with Nursing and Midwifery Council standards for learning and assessment in practice (NMC 2008). It would be expected that similar issues could arise for other areas of nursing and midwifery.

2.4 Conclusion to the literature review

Overall, the introduction of HCSWs and APs over the last decade has highlighted the growing need to look closely at clarity of role definition, regulation, the need for supervision and career progression supported by educational programmes that are relevant to the specific context of care (Hewitt-Taylor 2005; NES 2009a; Smith et al. 2007; Spilsbury et al. 2009; Warne & McAndrew 2004). At this time there is limited empirical evidence to support or challenge the evolving roles of SHCSWs and APs in supporting registered nurses and midwives both in the acute and community setting and in particular in children and young peoples services. The evidence regarding the impact on outcomes for service users is also limited (Spilsbury & Meyer 2004). The studies and evaluations that explore the educational needs of these workers and HCSWs to support the development of these roles do identify the need for supervision in the work place, situated or workbased learning and assessment supported by accredited programmes of study with opportunities for career progression. NHS Education for Scotland (NES) and the Scottish Social Services Council are currently reviewing this workforce's education and training needs and core standards for practice in response to the key drivers for workforce change (SMCI Associates 2009).

Section 3: Phase one results of scoping study of contextual location of the education programme, programme documentation and student population

3.0 Introduction

This section reports the results of the content analysis of the contextual location related to the Higher Education Institution where the education programme was being delivered, education programme documentation, module content and delivery methods, NES Capability Framework (NES 2009b), teaching team, mentors, assessment strategy, admission criteria, programme delivery costs and the student population.

3.1 Contextual location of the programme

Clear description of the context within which the programme was being delivered is presented in this report and is based on information gained from documentary evidence collected by the evaluation team, from the programme team, on the initial site visits in July and September 2009.

A School of Nursing and Midwifery in a Scottish University successfully secured a tender from NHS Education for Scotland to develop and deliver a national programme for senior healthcare support workers and assistant practitioners in children and young people's health and well being. The programme at this stage is considered a pilot, with the potential for national roll-out following its evaluation.

The Faculty of Health and Social care, within which the School of Nursing and Midwifery is located, has experience of developing similar *"assistant practitioner programmes in the field of maternity care and radiotherapy"* (RGU Volume 1: Overview and Resource Document 3rd March 2009). The current programme is presented as being in alignment with the School of Nursing and Midwifery's work in the development of a *'seamless lifelong learning platform...'* and contributing to the University's and the School's Mission Statements by developing new roles for the future of the NHS in Scotland:

"To inspire and enable the transformation of individuals, economies and societies", and "To inspire students to develop into professional creative leaders of nursing and midwifery." (RGU, 2009a, p.2)

Involvement in this education initiative is therefore a logical extension to the School's education activities. There is evidence of clear support for the programme within the RGU (2009b) *"Overview and Resource document"* as local child health service managers and the nurse consultant in paediatric palliative care from NHS Grampian contributed to the tender submission.

Scotland wide health policies are driving the development of education programmes for health care workers (see Literature Review pp 31-32). The Scottish Government Health Directorate (SGHD) directed NES to develop a core Capability Framework to act as a foundation upon which to build

education for Healthcare Support Workers (SHCSW). By using the *Capability Framework* approach the intention was provide a clear career pathway for HCSW with resulting education linking to both the frameworks of the Scottish Credit Qualifications Framework (levels 7 & 8) and the NHS Careers Framework (levels 3 & 4). The Capability Framework is thus a central pillar of the RGU education programme (SCQF Levels 7 & 8) for SHCSWs/APs in children's and young people's health.

3.2 Programme Documentation

The following section documents and analyses the planned programme based on an analysis of the programme documentation provided to the evaluation team. The focus is mainly on the programme aims and outcomes, the module content and delivery methods, domains of practice, the teaching team, mentors, assessment strategies, entrance criteria and costs of providing the programme. The documentation received from RGU is concise. The evaluation team was given a face to face demonstration of *Campus Moodle* at the initial site visits but ongoing access to *Campus Moodle* was not granted.

Documentation received by the evaluation team comprised the following:

- Student and mentor handbook
- Study Guide
- Module Descriptors
- Clinical Assessment Record
- Clinical Assessment Record guidelines
- Clinical assessment profile
- Capability Framework
- Pre programme self assessment
- Portfolio guidelines
- Module Booklets
- Overview and Resource document
- Detailed programme descriptor

NES (2009a) stated that the current education programme must be based on the "*working with children and young people, their families and carers*" Capability Framework. During its development the programme was mapped to the Capability Framework including the aims, outcomes, content of the modules and clinical assessment profiles. The programme was also mapped to SCQF Level descriptors at Level 7 and 8. The Capability Framework had in turn been mapped to the NHS Knowledge and Skills Framework.

The education programme was successfully validated on the 3rd of March 2009 and comprised eight modules in total, four theory based and four practice based across Level 7 and Level 8 of the Scottish Credit Qualifications Framework, with students expected to achieve 120 credits at both SCQF Level 7 and 8. The programme was predominately work based with content taught in the clinical setting and delivered online (*via Campus Moodle*). The programme spanned four semesters across two academic sessions with eight days of timetabled classes in total delivered within four residential study blocks.

Table 1: The programme structure (RGU, 2009a)

STAGE 1 (30 weeks SCQF 7 120 credits)	
SEMESTER 1	SEMESTER 2
Fundamentals of Children and Young Peoples Health, Wellbeing and Development	Pathway Module: Fundamentals of Early Years: Theory
Fundamentals of Children and Young Peoples Health, Wellbeing and Development Practice	Fundamentals of Early Years: Practice
2 Day Block: Introduction 1	2 Day Block: Introduction 2
STAGE 2 (30 weeks SCQF 8 120 credits)	
SEMESTER 1	SEMESTER 2
Children and Young People's Health, Wellbeing and Development: Concepts and Themes	Pathway Module: Early Years: Theory
<i>Children and Young People's Health, Wellbeing and Development: Practice</i>	Pathway Module: Early Years: Practice
2 Day Block: Introduction 1	2 Day Block: Introduction 2

RGU (2009a)

The programme aims and outcomes reflect the requirements from NES for appropriate education for Senior Healthcare support workers and Assistant Practitioners in children's and young people's health (NES 2009a).

Aim of the Certificate of Higher Education:

"To enable students to acquire a range of knowledge and skills so that they achieve the capabilities as set out in the capability framework and work in community based teams as a Senior Health Care Support Worker with Children and Young People"

Aim of the Diploma of Higher Education:

"To enable students to support children and young people, parents, families and carers, address inequalities create a positive health environment for children and young people and achieve the capabilities to work with Children and Young People as an Assistant Practitioner" (RGU 2009a).

3.2.1 Module content and delivery

As stated this programme was presented as being predominantly work based (RGU 2009a) offering an "effective combination" of practical experience and academic study. The programme utilised an online approach which aimed to provide students with learning flexibility (RGU 2009a).

Within the learning outcomes a clear distinction between academic levels SCQF levels 7 & 8 may also be required. For example in Level 7 semester one concerned understanding of CYP and their families across a range of settings (RGU, 2009a) and semester two was *"to enable students to recognise the role they and others play in supporting children and their families"* (RGU, 2009 a) which is surprising as this is a level 8 programme aim.

The modules covered the fundamentals of early years theory and children's and young peoples' health well being. The students began the programme and each semester with a two day residential block where they were introduced to foundational theory and skills" (RGU 2009a). They were also to be familiarised with the HEI's virtual learning environment (*Campus Moodle*). The opportunity afforded by the initial block for students to meet each other was believed to be invaluable for their future online work (RGU 2009a).

The *Campus Moodle* was thought to allow students to:

"engage in theoretical learning, reflect upon practice and enter into reflective dialogue with their mentors and supervisors" (RGU 2009a), but this cannot be evaluated without access to *Moodle* discussions.

The host HEI stated that they were also able to offer paper based materials and more traditional learning materials however how this would be delivered was unclear from the documentation (RGU 2009a). There is clearly a risk that these students could miss out on e-learning opportunities and the consequences of not developing peer relationships through the virtual environment were not addressed.

The two day block at the start of Semester two RGU (2009a) was designed to build upon the knowledge and skills gained in semester one. These two day blocks they assert would facilitate the development of a learning community. Success in this regard will be explored in phase three (page 44-60).

3.2.2 The five domains of practice (NES Capability Framework 2009c)

The evaluation team considered how the Capability Framework was applied in the programme, rather than undertaking a critique of the measurement properties of the tool which was beyond the scope of the evaluation. As this programme was intentionally mapped to the Capability Framework (NES 2009c) and indeed directly to the clinical assessment profile it should be commended for addressing all the five domains of practice. However as some of the content was to be delivered in the practice area and the specifics of this were not identified this could potentially lead to inequitable provision across students because mentors may interpret the content differently. Certainly in terms of modular content the amount of input students would receive in different topics was not clear and in particular it was not explicit how the content of ethical considerations, advocacy and sexual health would be delivered.

The main themes within the HEI module documentation were communication, inequalities, theory and skills, effective relationships and achieving the

capabilities; these clearly reflected the requirements of the Capability Framework.

It is unclear from the documentation how students would develop as reflective practitioners which is a requirement of the Capability Framework (NES 2009c) and thus further elaboration would be needed for such. In terms of partnership working it remains difficult to ascertain the level of practice experience a carer working in isolation would undertake if working in a single client environment.

3.2.3 The teaching team

The teaching team at the host HEI comprised lecturers, a programme leader who was an experienced nursing lecturer, module coordinators, and a senior lecturer in *Innovative Learning*. Each student was to be supported by a mentor in practice. The entire programme was supported by a programme team with representatives from the host HEI, NHS Grampian, Aberdeen City Council, and Aberdeen College.

3.2.4 Work-based mentors

Work based mentors had a crucial role within the programme as according to the HEI they would “...support the application of theory to practice, offer practice development support and assess the development and achievement of the required capabilities” (RGU 2009a p.5). Mentors, they stated, were involved from the outset and their attendance at a mentor session in the initial block would have been important. However, the extent to which these aims were really feasible or achievable will be explored later in phase three of the current evaluation. The host HEI intended that the workplace setting would enable students to work with a variety of professionals and others however the evaluation team found particularly in phase three that some programme participants in carers roles worked in isolation with their clients. It was unclear from the documentation how this anomaly would be reconciled.

The students needed to be currently working in a children or young person’s health setting with access to a variety of experiences to ensure achievement of the Capability Framework (NES 2009c). It is unclear how this would be feasible for students in solitary workplace experiences often in people’s own homes. There was it appears some responsibility for the employer to provide an appropriate area of practice and employer’s responsibilities for placements were articulated clearly in the programme documentation (RGU 2009a). This included ensuring that students were adequately supported and mentored. A *Placement Agreement Contract* was in place to ensure this though evidence of this documentation was unavailable to the evaluation team. The employer responsibilities included ensuring that students received one day per week protected learning time pro rata for the student’s employment contract. In practice awareness of the content of placement agreement contracts seemed variable as evidenced by some of the findings in phase three. Nonetheless, the programme team should be commended for the development of *student learning contracts* and *placement agreement contracts* which made clear the mentor, employers, and students’ roles and responsibilities.

Mentors were required to judge the students' achievement of the capabilities however the level or amount of evidence required for each capability is unstated, as is the acquisition of specific practical skills in the students' sphere of practice. It could be argued that this could potentially result in inconsistencies across levels of assessment. It is also not clear from the documentation how each individual capability would be demonstrated through a learning portfolio. In the measurement of *satisfactory and safe* further clarification is required as to how this judgement would be made. There are no specific guidelines for mentors with regards to the level or amount of evidence required for fulfilling the NES *capabilities* in practice and this point will be explored in the discussion.

3.2.5 The assessment strategy

The host HEI states that SCQF level descriptors provided the foundation for the assessments at level 7 and 8. Formative assessment was to be ongoing and guidance on performance was to be given throughout. The summative assessment at level 7 was a portfolio of evidence providing achievement of capabilities and at level 8 an extended assignment demonstrating achievement of the learning outcomes was required (RGU 2009a).

Assessment methods and assignments were mapped to SCQF levels and the NES Capability Framework (NES 2009c). The assessments were aligned with the aims and outcomes of the modules. With regards to the appropriate level in practice however there is a blurring between the requirements for SHCSWs and APs and the clarification of such was not clear. The emphasis on cognitive dimensions within the capabilities in the clinical assessment profiles used to record practice achievement should be reviewed to determine whether an improved balance between cognitive, affective and motor elements of the various skills linked to the capabilities would be appropriate.

The mentor would undertake the final practice assessment and a pass or fail grade was to be awarded accordingly for practice. The host HEI (RGU 2009a) asserted that a *Skills Passport* would be used to record skills achievement but it is unknown if these would include specific or core skills at the appropriate level. Within the evaluation data nobody referred to the *Skills Passport* so it is unclear if these were being used, and if not, it could make the practice assessment less robust. Peer assessment was also noted as being integral to the programme with the use of assessment grids (RGU 2009a), but it is unclear how this was operationalised. Peer assessment was not referred to by anyone in the evaluation data reported later.

3.2.6 Admission criteria and university regulations

Applicants to this programme were subject to normal admission criteria for all students applying to the university however they also had to be currently employed in a children or young person's practice situation. The documentation from the HEI (RGU 2009a) stated that students were required to have access to a computer and the internet. If this requirement was not consistently applied it could result in inequity of educational opportunities.

There was a contradiction however in that the documentation stated that hard copy would be provided if students did not have access to the internet (RGU, 2009a). Students were also required to attend residential block days supported by their employer. *Disclosure Scotland* screening was essential (RGU 2009a). Decisions concerning direct entry to Level 8 were as a consequence of the application of the HEI's accreditation of prior learning processes to applicants who held a Level 7 award in children's and young people's health.

3.2.7 Costs of programme

The HEI received £50,000 for the development and delivery of this programme to the initial two cohorts. This is believed not to have covered the full costs of the programme to the HEI (verbal report to the evaluation team Principal Investigator in March 2010, by the HEI Manager). No further costs information was provided.

3.3 Student demographics

Routine and anonymised data collected on students who commenced the programme are provided in the tables below.

Table 2: Cohort 1: Number of students by NHS board n=8

Work Base Area	Student numbers
NHS Ayrshire and Arran	3
NHS Fife	3
NHS Greater Glasgow and Clyde	2

Table 3: Cohort 2: Number of students by NHS board n=24

Work Base Area	Student numbers
NHS Greater Glasgow and Clyde	7
NHS Ayrshire and Arran (Health & Wellbeing in Schools Project, Demonstration site)	2
NHS Forth Valley	2
NHS Forth Valley (Health & Wellbeing in Schools Project, Demonstration site)	2
NHS Grampian	3
NHS Grampian (Health & Wellbeing in Schools Project, Demonstration site)	5
NHS Highland	2
NHS Orkney	1

Table 4: Cohort 1: Number of students by role n=8

Student Role	Number of Students
Family Support Worker HV Team	2
Clinical Support Worker HV Team	1
Public Health SW Improving Health Team	1
Breast Feeding SW Worker	2
HC Support Worker Health Visiting Team	2

Table 5: Cohort 2: Number of students by role n=24

Student Role	Number of students
Support Worker	6
Family Support Worker	2
Family Support Worker Health Visiting Team	1
HCA School Nursing Team	2
Health Visiting Team Support	1
Physiotherapy Support Worker	1
Home Care Ventilation Support	2
Speech and Language SSW	2
Language Support	1
SHCA Acute Sector	1
SHCSW Acute Sector	4
Family Support Worker Parenting Programme	1

3.4 Conclusion

The above certificate and diploma in higher education programme aimed to provide accreditation in learning for support workers in care settings for children and young people's health (CYPH). The development of a programme in this field is to be welcomed. The host HEI and the School of Nursing and Midwifery are committed to promoting and enabling the transformation of individuals, economies and societies and through the process of lifelong learning to inspire students to develop professionally. The School of Nursing and Midwifery has prior experience of delivering assistant practitioner programmes in related fields and this experience may well have informed the development of the current programme.

The programme documentation is concise, clear with indicative content relevant to the SHCSW and AP roles in CYPH. A blended curriculum is proposed that comprises face to face residential study blocks, e-learning, work based learning and an element of peer or group learning. The programme is closely aligned to the Capability Framework (NES 2009c). It was envisaged that students would cover significant amounts of content in work based learning components. This indicates a need for transparency in the education process so that mentors can provide appropriate support and guidance, and so that students are exposed to similar work based content. The differences between SHCSWs and APs could be more explicit in relation to programme content, capabilities, learning outcomes and SCQF levels 7 and 8.

The capabilities within the clinical assessment portfolio are based on the Capability Framework (NES 2009c) and are specific to SHCSWs and APs in children and young people's health. This could restrict students' transfer to other parts of the health and social care workforce. In particular, it is not clear how relevant the programme would be for social care support workers. Currently this is not a UK-wide recognised programme and so there is a risk that this group of students could be disadvantaged if they wished to change employment.

Section 4: Phase two survey and repeat survey of programme participants

4.0 Student questionnaire survey one

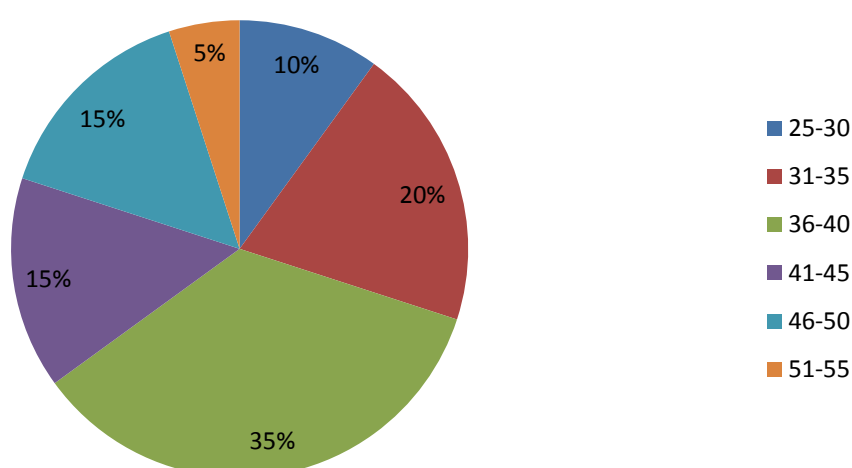
The first questionnaire, information sheet and consent form were distributed to matriculated students (n=32) undertaking the Senior Health Support Worker (SHCSW) (SQCF Level 7) or Assistant Practitioner (AP) (SCQF Level 8) in Children and Young People's Health pathways by the Queen Margaret University (QMU) researchers at a face-to-face meeting at the host HEI at the beginning of September 2009. A follow up was sent by post by the HEI at the beginning of October 2009. Reminders about the study were emailed to students and posted on *Moodle* via the host HEI on three occasions (18 Sept, 13 Oct, 26th Oct). The data from five respondents from Survey 2 have been added in here as it was the first (only) questionnaire they had completed. Six participants returned a second survey questionnaire, and where relevant, these data have been included in the analysis.

4.1 Profile of programme participants

Descriptive statistics

A total of twenty respondents out of 32 returned first survey questionnaires, giving a response rate of 62.5%. All respondents except one were female, white, and from Scotland, except two from England. Their ages ranged from 25 to 55 years, with the majority (35%) in the 36-40 age group (see Figure 1: Participants by age).

Figure 1: Participants by age (years) n= 20



Nineteen participants were employed by the NHS, with one employed by a local authority. Respondents worked within six Health Board areas (Fife, Highland, Grampian, Forth Valley, Greater Glasgow and Clyde, and Orkney), and one council area in the Highlands. In 2009, The Scottish Government began a two year project, Health and Wellbeing in Schools, to increase health care capacity in schools, with the aim of developing an integrated model of effective health care by harnessing existing skills whilst at the same time developing new roles. Four demonstration sites were set up to test the new model, and staff involved in two of these pilots in Grampian and Ayrshire and Arran, and working in associated new roles, were participants in this study.

4.2: Academic and employment background

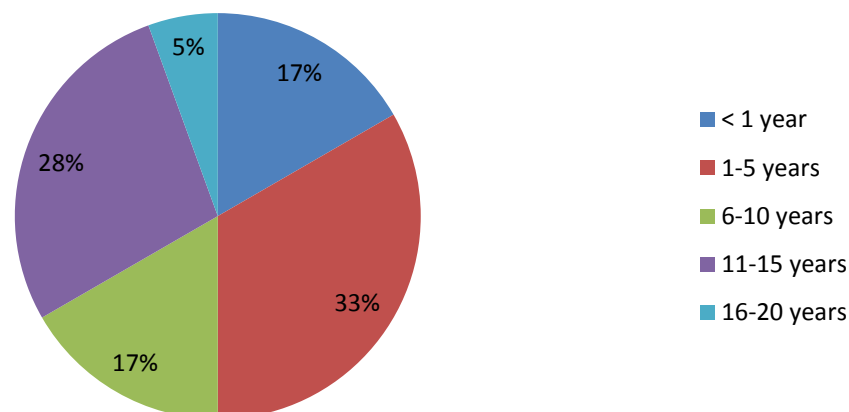
Academic Qualifications

Highest academic qualifications attained (not related to children and young people) included an MA in Geography, a BSc in Engineering, a BSc in Complementary Therapies, and a Diploma in Hotel Catering and Institutional Management and an English Higher. Five reported holding qualifications relating specifically to children and young people - HND in Childcare and Education, HNC Early Education and Childcare, Professional Development Award, Level 8 in Early Education and Childcare, and Early Years Education, and a Nursery Nurse Examination Board Qualification in Childcare. Two respondents had an HNC in Social Care, one an HNC in Supporting Learning Needs. Two had an SVQ in Care and another had obtained a variety of SVQs. Qualifications dated back to 1978 in one instance, and as recently as 2009 in two other cases. Just under half of the participants reported having undertaken academic study within the last five years.

Length of Experience working with children

When asked how long they had been involved in working with children, respondents ranged in experience from one month, to 20 years (see Figure 2), with one non-response:

Figure 2: Length of time employed in work with children (n= 19)



Current Programme

Thirteen respondents were enrolled on the Senior Healthcare Support Worker programme, and six were enrolled on the Assistant Practitioner programme. One respondent reported being enrolled on both programmes.

Current employment

Current posts at the time of embarking on the programme held by the respondents are shown in the following table (Table 6: Survey respondents by job title, role and grade).

Table 6: Survey respondents by job title, role and grade

Job Title	Role and Grade
Public Health Assistant	Supporting Improving Health team
Children's Services Worker (Early Years)	No details given (employed by Council, so not in Agenda for Change framework).
Family Support Worker	Working as part of the health visiting team, Band 4
School Health Assistant	Health Assistant within the School Nurse Service
School Health Support Worker	Support to School Nurse Team, Band 3
Nursery Nurse	Band 4
Home Carer	Care for a ventilated child at night
Breastfeeding Support Worker	Support breastfeeding mothers, Band 2
Technical Instructor	Speech & Language Therapy Grade 4
School Nurse Support Worker	Grade C
Community Nursery Nurse	Working alongside Health Visitors in a community setting, Band 4
Clinical Support Worker	Supporting Health Visiting Team, Band 3
CNN/Home Carer	Home Carer (Band 3) and Community Nursery Nurse (Band 4)
Plaster technician	Band 3
Ventilation support worker	Band 3
School health care assistant	No information provided
Therapy Support Worker	Physiotherapy assistant, Band 3
OT assistant	Band 3
Support Nurse	Band D/E ?Band 5
Nursing Support	Grade 3

Change to employment on completion of current programme

None of the participants anticipated a change in their job title, role or grade subsequent to completion of the respective SCQF7 and SCQF8 programmes, although one stated she hoped to progress to a Grade 4. Two indicated their desire for career progression, one by undertaking further study to become a health promotion officer (this respondent had no previous health training), and another to become a midwife.

Reason for undertaking current programme

Participants were asked to provide for reasons for undertaking the current programme. Two declined to do so. Five participants stated it was a requirement of the post they had been offered, with another reporting that the NHS was paying, or at least supporting, the programme fees, which relates to the demonstration sites and associated new roles discussed above. The remainder reported it was to further their career; by giving them an insight into child health and current legislation; giving them a chance to improve their knowledge, understanding and skills; and to facilitate promotion, or acceptance onto subsequent programmes.

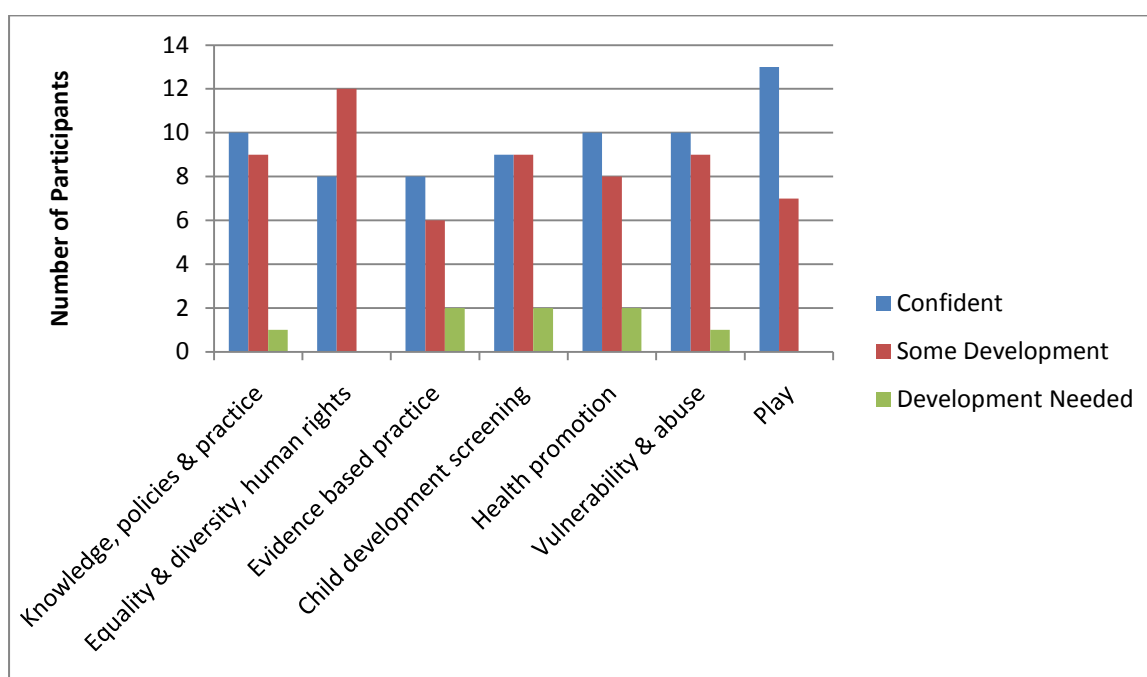
4.3 Self-rating of levels of confidence in CURRENT practice.

Participants were asked to self-rate their level of confidence relating to competence statements under five themes, Knowledge for Practice; Partnership Working; Practising Ethically; Care and Intervention; and Personal, Professional and Service Development (for all competence statements, please see Appendix 2 Participants Questionnaire, section 3). For each statement, they were asked to state whether they were 1) Confident and already do this competently; whether 2) Development was needed in some aspects; or whether 3) Development was needed in most, or all, aspects of this area. The results are shown below.

Theme 1: Knowledge for Practice

1.1 The practitioner continually maintains and develops an integrated knowledge of the legislation and policy that forms the current framework in which they practice and the health and care needs are addressed.

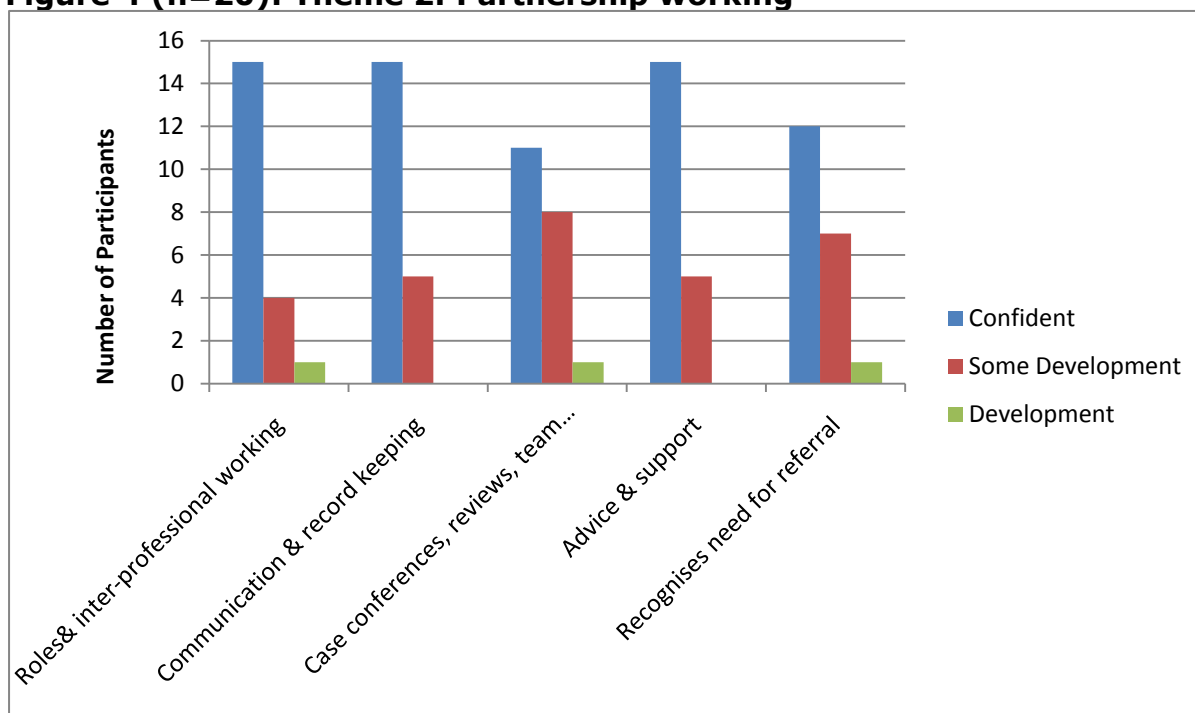
Figure 3 (n=20): Theme 1: Knowledge for practice



Theme 2: Partnership Working

2.1 The practitioner understands the concept of multi-agency working, ensuring effective communication, continuity and consistency of children's care within and across settings.

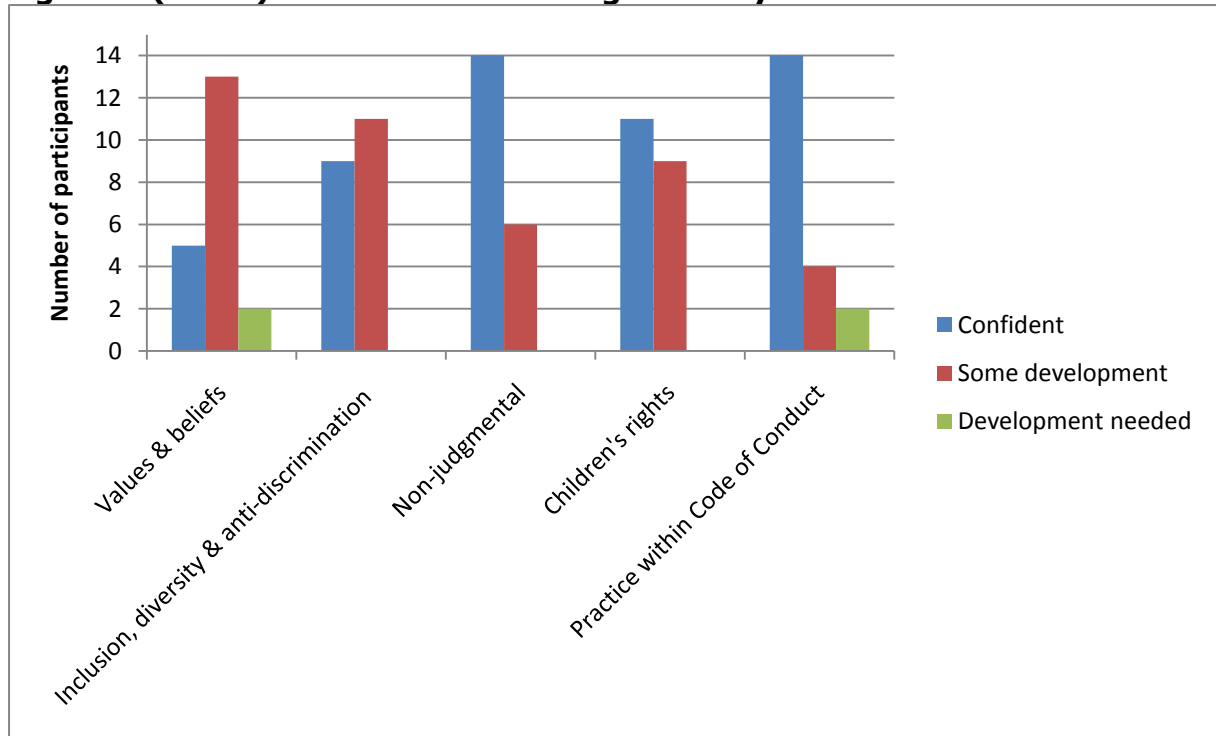
Figure 4 (n=20): Theme 2: Partnership working



Theme 3: Practising Ethically

3.1 The practitioner can demonstrate knowledge of cultural and ethical factors influencing parenting and lifestyles and can practice in a relevant, sensitive and non-judgmental manner.

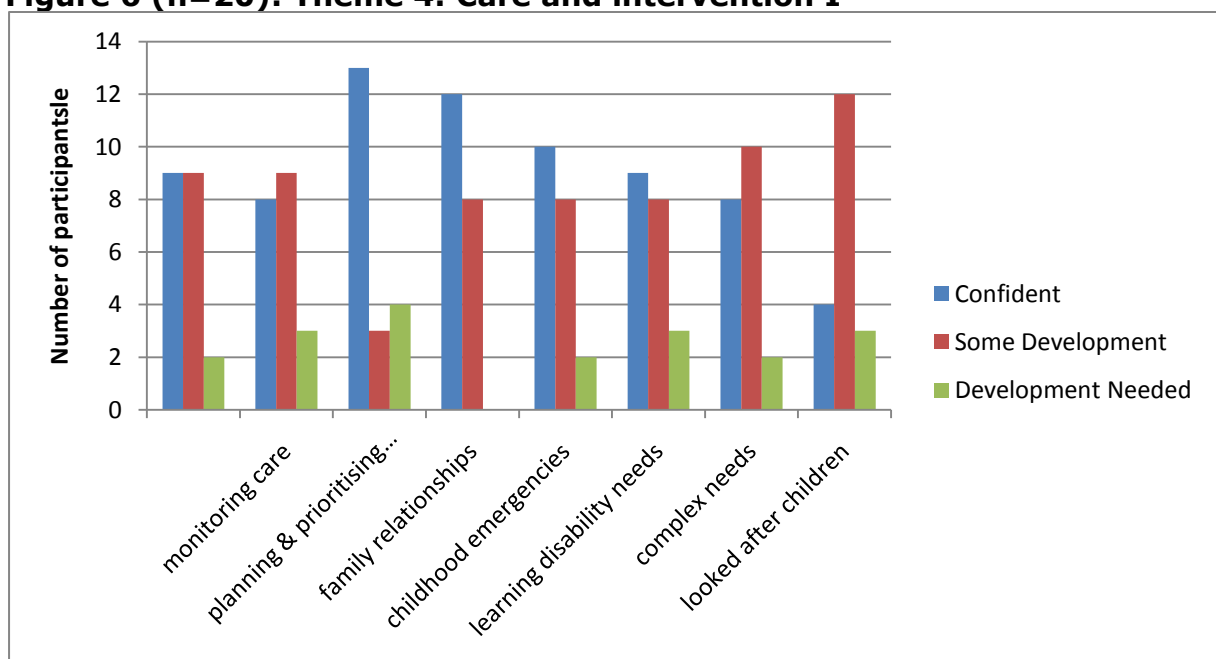
Figure 5 (n=20): Theme 3: Practising ethically



Theme 4: Care and Intervention

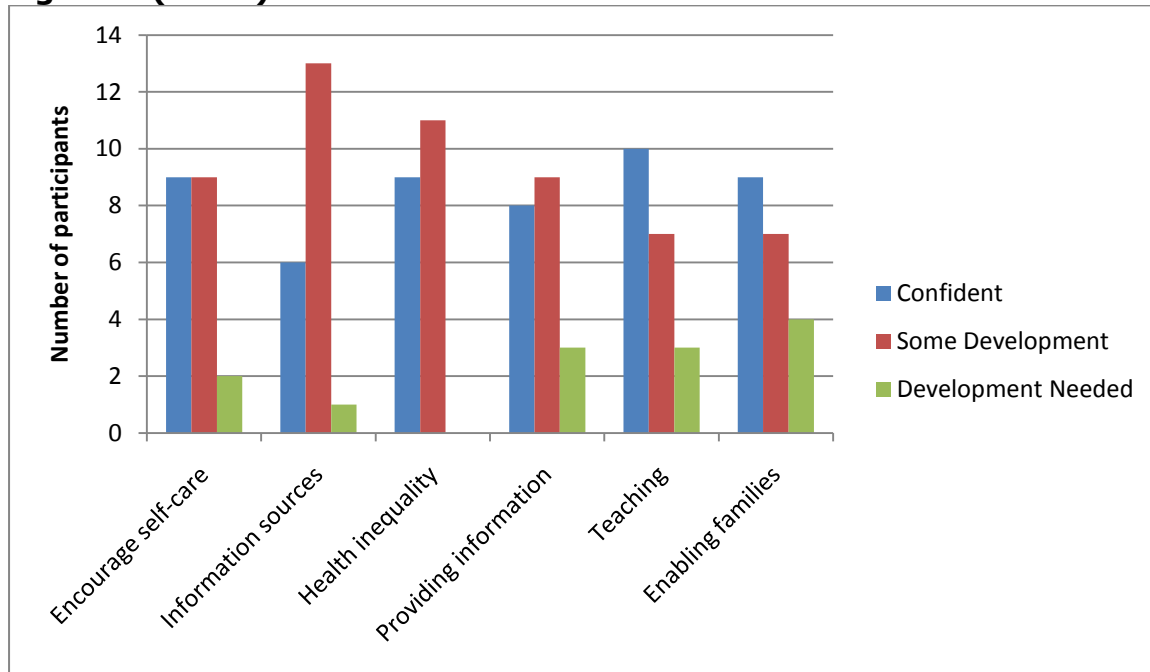
4.1 The practitioner develops his or her knowledge and understanding of children to contribute to the assessment of the holistic needs of the child and young person, their families, carers and communities and to provide evidence-based care.

Figure 6 (n=20): Theme 4: Care and intervention I



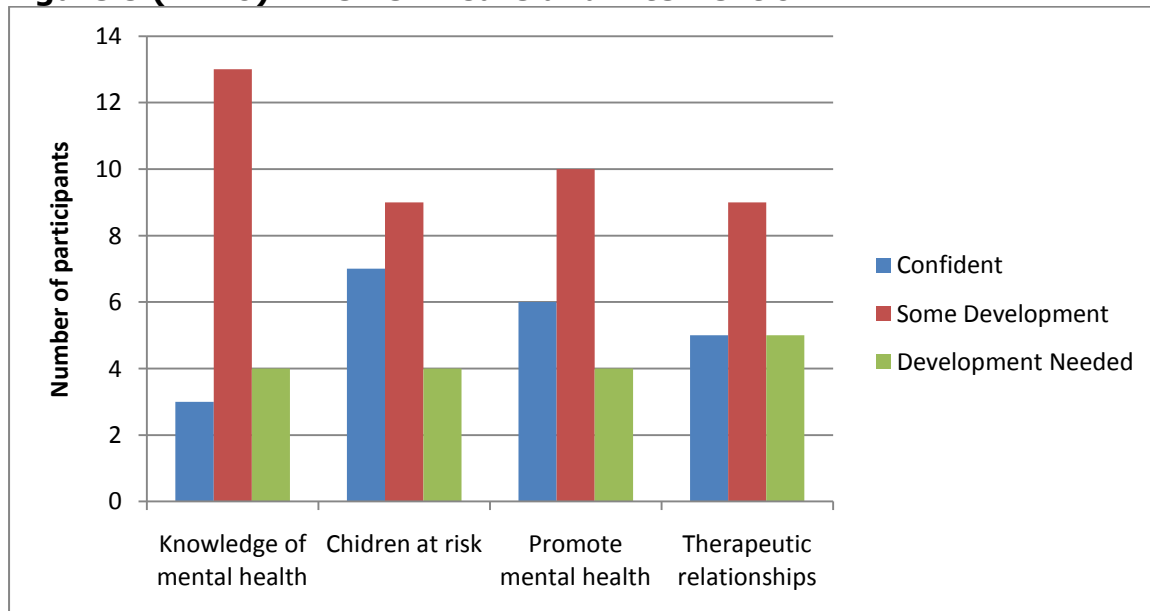
4.2 The practitioner, working with others, contributes to the promotion of health and wellbeing, quality of life and self-care capacity for children, their families and carers.

Figure 7 (n=20): Theme 4: Care and intervention II



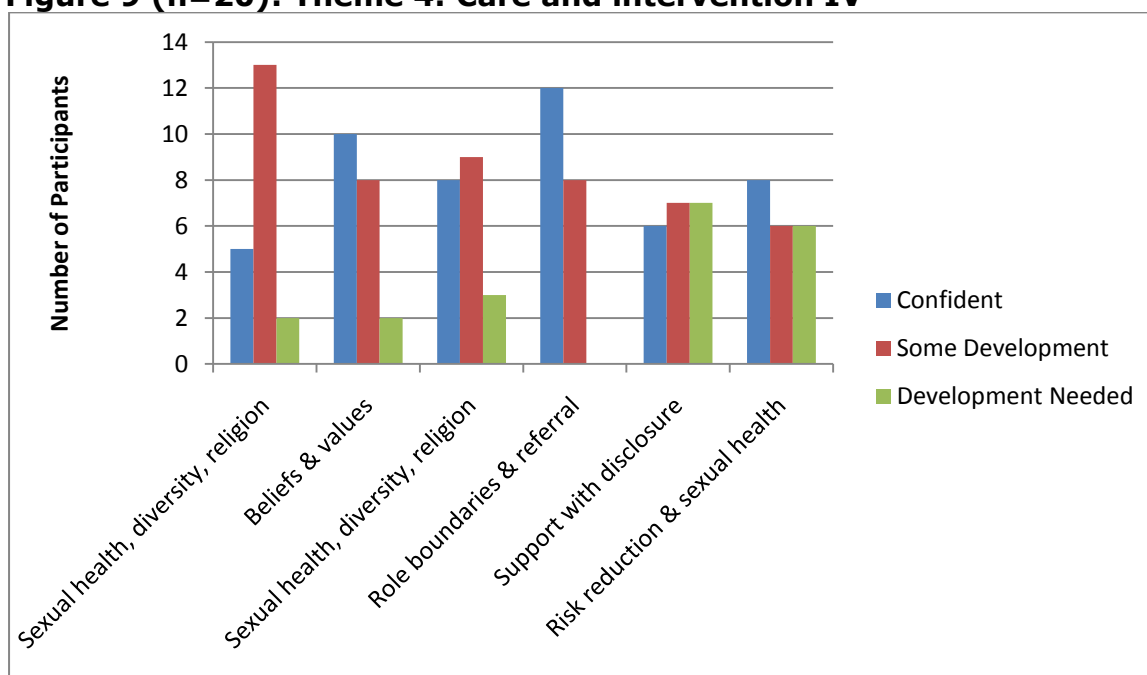
4.3 The practitioner, working with others, applies knowledge and skills to contribute to the mental health and wellbeing of children.

Figure 8 (n=20): Theme 4: Care and intervention III



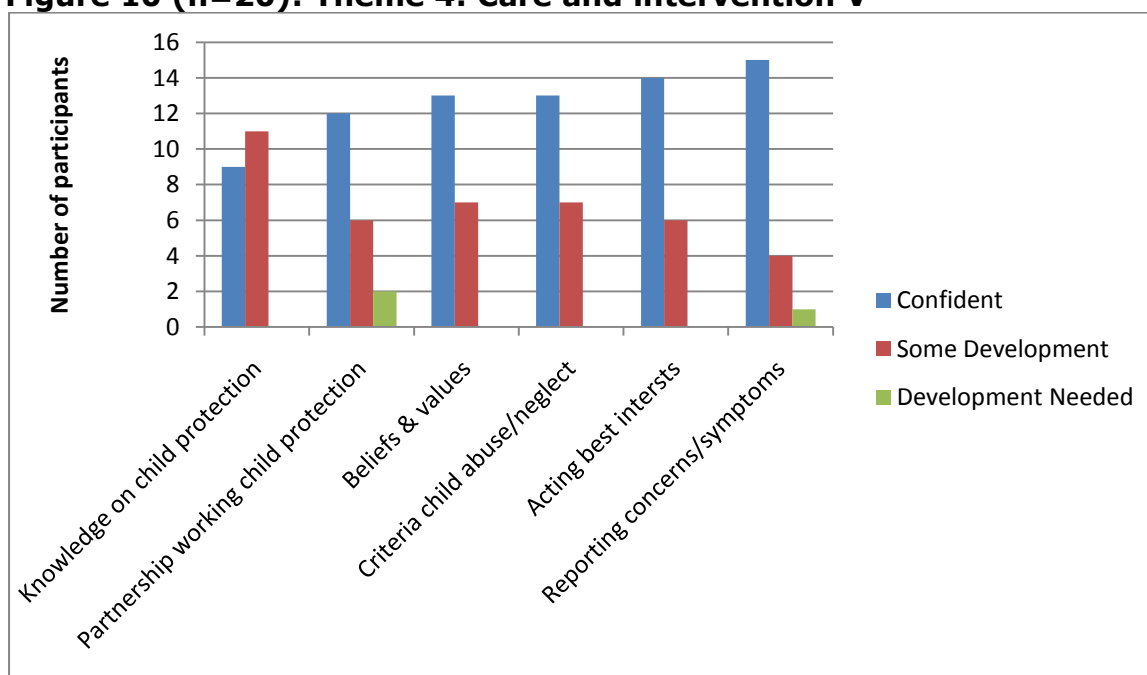
4.4 The practitioner, working with others, applies knowledge and skills to contribute to the sexual health and wellbeing of children and young people in the promotion of positive relationship as appropriate to age.

Figure 9 (n=20): Theme 4: Care and intervention IV



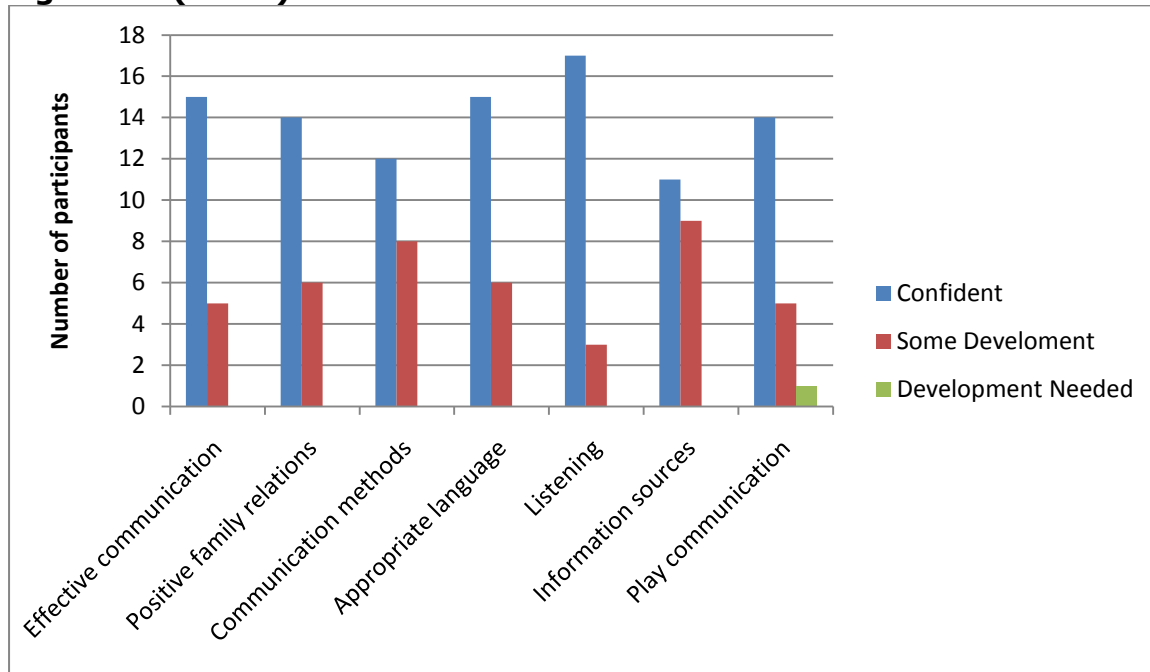
4.5 The practitioner, working with others, applies knowledge and skills to identify any circumstances that may harm the health and wellbeing of children and contributes to protection from and identifying abuse or potential abuse.

Figure 10 (n=20): Theme 4: Care and intervention V



4.6 The practitioner continually develops and utilises interpersonal skills to facilitate effective communication with children and young people to enable them to understand their health and wellbeing.

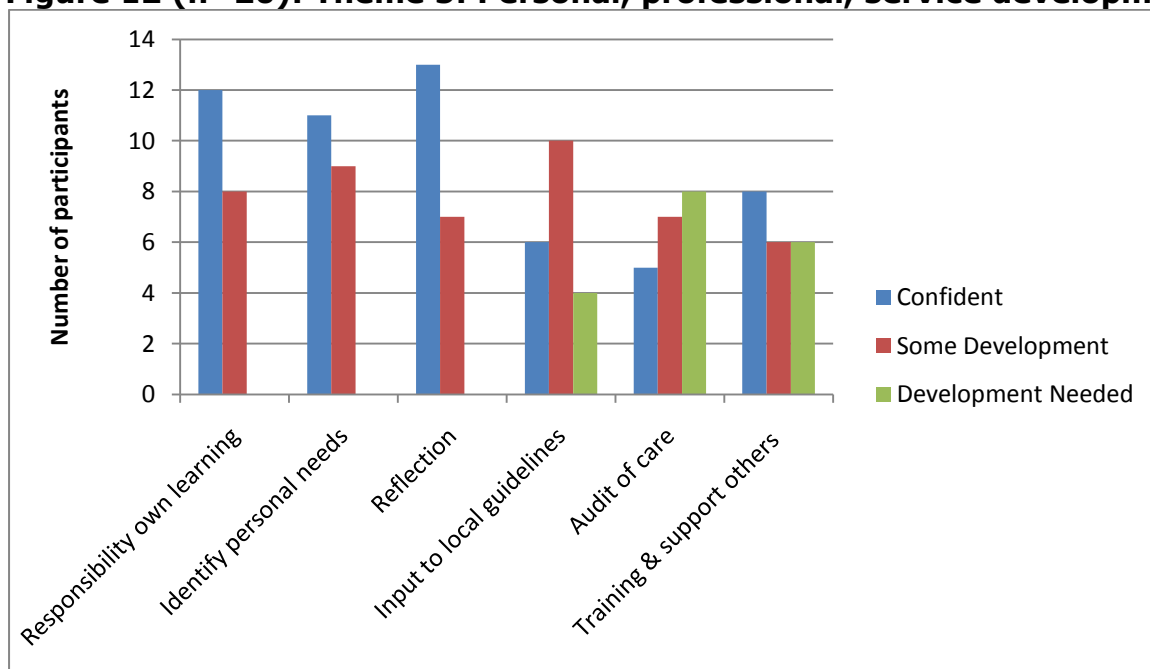
Figure 11 (n=20): Theme 4: Care and intervention VI



Theme 5: Personal, professional and service development

5.1 The practitioner maintains and develops knowledge and practice by participating in life long learning, personal and professional development planning and through supervision, appraisal and reflective practice with colleagues.

Figure 12 (n=20): Theme 5: Personal, professional, service development



It can be seen from the above graphs that at the time of undertaking the programme, there were mixed perceptions regarding competence statements across the various themes. Overall, it was felt there was need for some development (red) across most of the areas. Thematic areas where participants showed the highest levels of confidence (blue) were in Partnership working (2.1); in identifying and dealing with issues pertaining to harm or abuse (4.5), and using their interpersonal skills to effectively communicate with children and young people (4.6). Participants reported the lowest levels of confidence (green) in relation to assessment of holistic needs of children and young people (4.1), health promotion (4.2), mental health (4.3), sexual health (4.4), and areas within personal, professional and service development (5.1), particularly audit of care and provision of training and support to others under supervision.

4.4: The application process for the education programme

The two programmes, Senior Healthcare Support Worker (SHCSW), and Assistant Practitioner (AP), began in September 2009. Participants were asked when they had applied for either of the programmes. More than half of the respondents had applied for a place either the month previously or the same month the programmes started, which in part was linked to the fact that one of the demonstration sites experienced delays in appointing to the newly created posts. One participant had applied eight months prior to the programme, and the remainder had applied between four and six months ahead of the programme commencement.

Eighteen of the nineteen respondents had heard about the education programme from their manager(s). Other reported sources were peer/colleague, Higher Education Institute contact, NHS Education Scotland (NES) website/circular, and the HEI website. Ten respondents reported having had between 1-2 weeks to submit their application, nine reported having more than two weeks, and one did not reply.

Asked to give their motivations for applying for either of the education programmes (they were able to give more than one reason), the majority (16) stated that it was an opportunity for general development, eleven said it was an educational opportunity, twelve said it was an opportunity for career enhancement, and two stated it was a requirement of their current post (working in one of the demonstration sites).

Participants were asked to state what they hoped to achieve by successfully completing the SHCSW or AP programme. Their comments are given in Table 7 below:

Table 7: Aspirations on completing SHCSW/AP programme

As my degree is not in public health, I hope it will assist my experience, concentrating on the area of early years.
I wanted to develop my knowledge of children and young people health and wellbeing as I moved to a new post. My current knowledge is more education based
I hope to achieve a better understanding of the health and well being issues facing children, young people and families today. I also hope to be better placed to make positive contribution to maintaining/nurturing the health and wellbeing of our young people.
Greater knowledge and skills enabling me to support the children and young people I am working with successfully.
Greater knowledge of work related topics which are occasionally touched on during a day-to-day work load.
Getting on programme to gain more knowledge and improve my skills.
A wider knowledge, together with a professional qualification on the health, wellbeing and development of children and young people. Also a pathway into further education, as intending to continue studying when programme completed.
Achieve certificate and diploma in CYPHE. Personal achievement and also to give opportunities in future career steps.
A greater understanding and knowledge of my job.
Gain knowledge and understanding to enable me to perform my role at my best, or to enhance my career opportunities.
To enhance my knowledge and understanding and also to explore new ideas, legislation and techniques; adding to my CV.
A better understanding of record keeping and further my skills.
Further my education, to help develop a better insight when working with children both in hospital and the community.
Giving me the qualification on paper that allows me to take forward my career.
Basic understanding of child development and current care practices/legislation relating to CYP.
Progression in my career. A more in-depth knowledge of CYP from a health perspective.
Learn more about my job and also to give more to the children in my care.
To be able to update current knowledge, also allow me to have more responsibility within my workplace, to be of more assistance to nursing staff. I generally like to learn and update my knowledge and promote my own skills, so I can be more valuable during busy times within my workplace.

4.5: The programme content, programme delivery methods and assessment.

Participants were asked to state which parts of the programme content they found the most useful preparation for working with children and young people. Two participants did not respond, and a further four stated that they felt it was too early in the programme to say. The remaining participants found the following areas useful: children and young people's growth, ways of gaining essential assessment of CYP; development and communication (including play aspect); learning about theory and policy documents, such as GIRFEC (Scottish Executive 2006a); determinants of health; interagency partnerships; meeting programme tutors and other students, learning new IT skills and how to use the university *Moodle* website; record keeping; religion and cultural diversity, and learning to understand other people's attitudes.

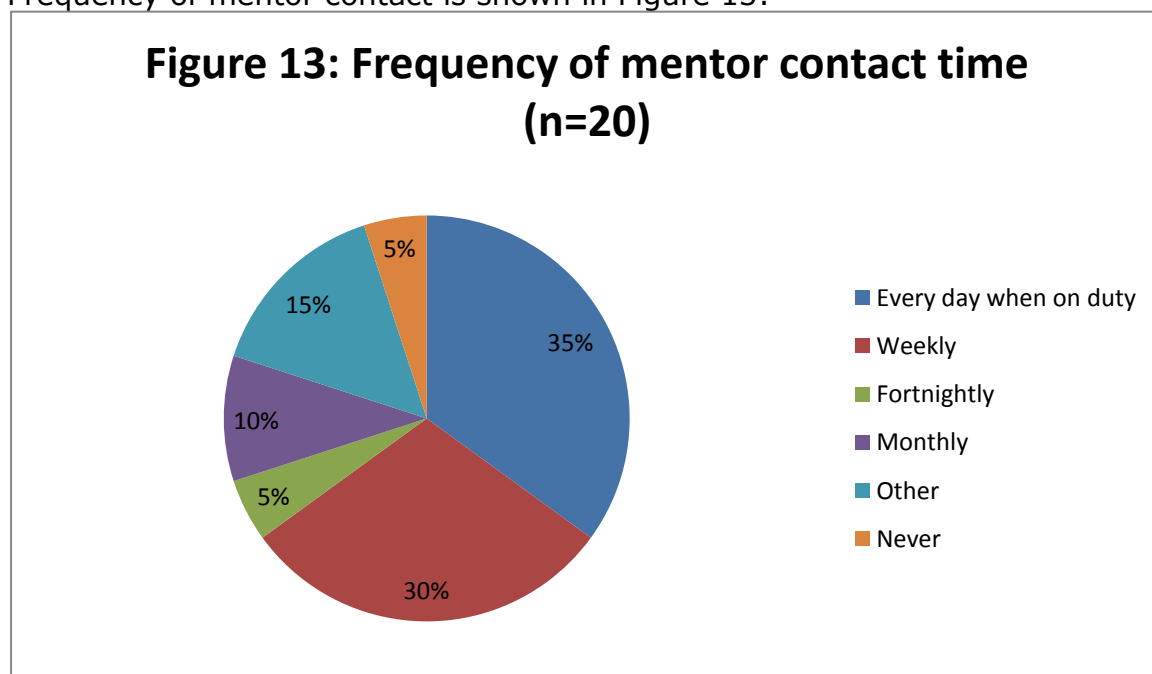
However, one respondent said that they felt their previous experience outweighed the programme content to date.

Similarly, participants were asked to state the programme content which was least useful for preparation. Six stated it was too early in the programme to say, seven said that thus far it had all been useful. One respondent felt the tutors were not sufficiently prepared for the students and that the two days' residential block were a waste of time, another felt that the time at university could have been more suited to meet the needs of individual students, and another stated that they did not feel the need to view mock up wards.

In terms of the distance and online learning methods in meeting the programme requirements, four did not reply, six found them very useful, four found them useful and six were undecided.

Participants were asked to outline their perception of the role of the mentor, prior to starting the education programme for the SHCSW or AP. Two did not respond. The majority felt the mentor's role was to offer them support, advice and guidance, give experienced input, a person to sound ideas off, someone to share with and listen to you. There was an expectation that the mentor would be aware of the programme content, assess student's skills, and ensure learning outcomes were met and practised in the workplace. To this end, one participant commented that they felt mentors should attend the University for the entire two day initial block, in order to identify and clarify their role. All six of the participants who returned a second survey questionnaire retained the same mentor.

Frequency of mentor contact is shown in Figure 13:



It can be seen that the majority of respondents met their mentor on a daily or weekly basis. For the three respondents who had stated other, one said mentor contact time had not yet been established, another stated it would occur rarely, and a third stated that undertaking shift work prevented them

from meeting their mentor frequently. The participants who said 'never' qualified that as being for the duration of the first module. One participant who reported monthly meetings said they would have contact with more than one mentor, as their job entailed covering a wide geographical area. Another participant reported formally meeting their mentor approximately once every three months, but worked with them most days, so did receive ongoing.

Participants were asked to describe the format of their mentoring sessions (see Figure 14), excluding the participant who had said they would not be meeting, and one other person did not respond. Two thirds of respondents reported having structured or fairly structured meetings with their mentors. Of the six respondents who returned a second questionnaire, four reported the same format of meeting, one had gone from no meetings to structured meetings, and one from structured to fairly unstructured meetings.

**Figure 14: Structure of mentor meetings
(n=19)**

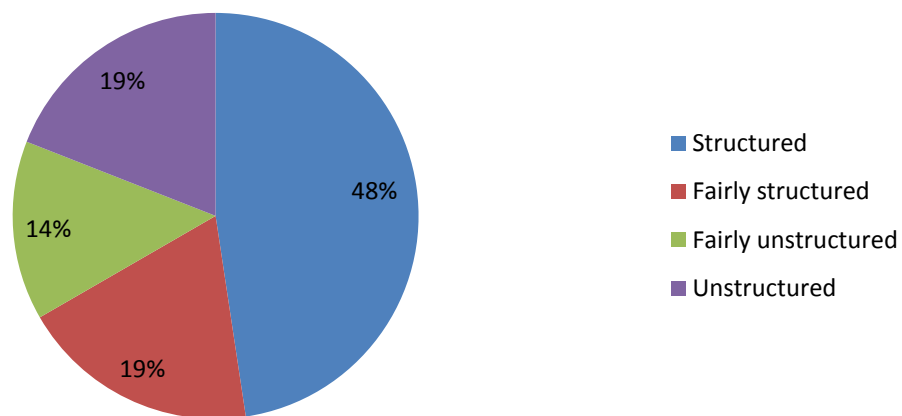
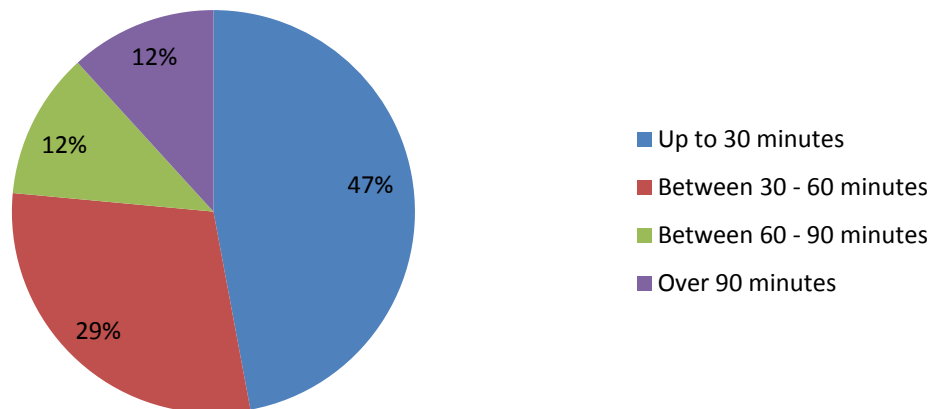
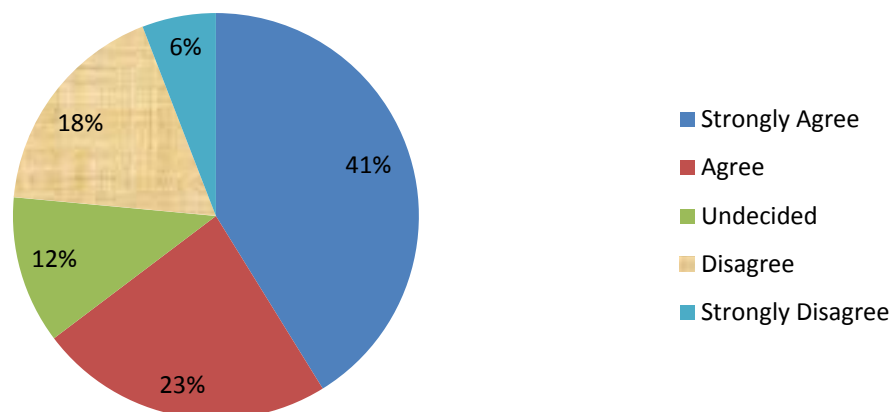


Figure 15: Length of mentor meetings (n=17)



The majority of respondents met with their mentors for up to 30 minutes, with nearly one third meeting for between 30 and 60 minutes, and then equal numbers reporting meetings of up to 60 minutes and up to 90 minutes in length. Of the six participants who returned a second questionnaire, three reported no change in meeting length (all up to 30 minutes), two reported reduced meeting length, and one reported having no meetings previously to meetings of up to 60 minutes in length.

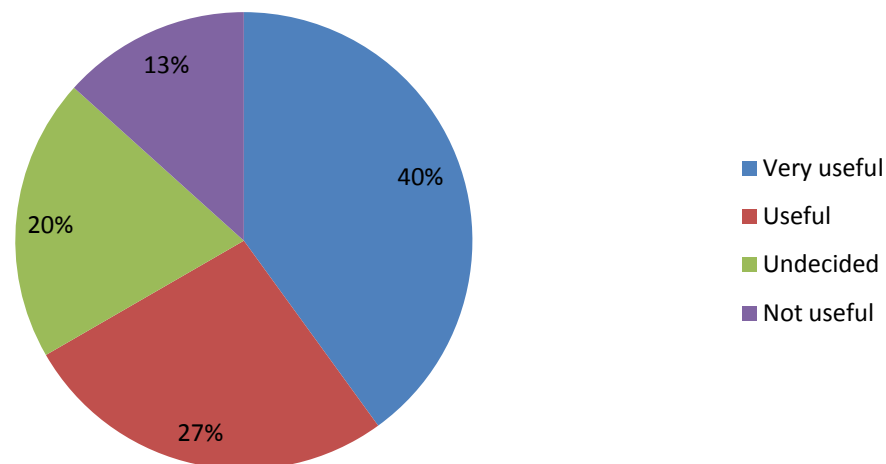
Figure 16: Expectations of mentorship matched by experience (n=17)



Of the seventeen participants who responded, having met with their mentors, eleven agreed their expectations had been met, four disagreed, and two were undecided. Of those participants who returned a second questionnaire, two who had not previously responded said that their expectations had been met,

and three were now undecided, and one remained in agreement that they had been met.

Figure 17: Usefulness of mentorship (n=15)



In terms of the usefulness of mentorship, fifteen participants responded, of whom ten felt the mentorship was very useful or useful, three were undecided and one reported it was not useful. Results from the second questionnaire showed that three participants continued to think the sessions were useful, two who had not previously replied both said they felt the sessions were useful, and one had moved from not useful to undecided.

Participants were asked to provide comments regarding their experience and perceptions of the two education programmes that might assist future programme development. Two respondents made comments regarding mentoring, saying they felt mentors should attend the preparatory sessions at university in order to realise the programme content and expectations, and determine that they are within the capabilities of their students; one student commented that the programme was much more work than they had anticipated. One respondent reported having experienced problems accessing the *Moodle* website, for various reasons, but usually university-related IT problems. Two felt more information around getting started on the programme would be helpful, with details of what was expected of the students, more support for community workers and clear and more definite time for studying. One respondent felt the programme could be condensed as there was too much sitting around and another said that it was not good in terms of time, expense and organisation to attend, but that it was good for networking purposes. Positive feedback was given by a participant who stated that they were fully enjoying the programme and would highly recommend it to support workers, and that they thought the on-line learning and tutors were fantastic. One respondent appreciated the allocated time to attend the programme.

4.6 Programme outcomes

Few participants completed this section, which is not surprising as most had only recently commenced the programme. Eight agreed that completing (or by completing) the programme had enabled (or would enable) them to gain the competencies for a SHCSW/AP role in children and young people's health; six that it would increase their chances of gaining SHCSW/AP post in CYP health; nobody reported that as a result of the programme they did not wish to work in CYP health, and eleven participants reported the programme to be a worthwhile development experience regardless of future role opportunities in CYP health, with one undecided, and the remainder did not respond.

Participants were asked to state what they felt to be the main strengths and limitations of the programmes in Children and Young People's Health programme. Very few commented, as the majority of respondents stated they felt it was too early to tell. The programme content was praised, for its breadth, the formative assessments, and the theoretical and online learning materials, which were felt to be of a high standard. One respondent felt they had gained strengths in being able to make child health assessments and in decision making, and were more aware of current government policies, particularly GIRFEC, and generally felt more valued. One participant appreciated the distance learning element which allowed them to study at times convenient for work and family commitments. Another appreciated the opportunity to mix with workers from other areas of child and young people's health care. The tutors were appreciated and felt to be accessible and helpful.

In terms of limitations of the programme, one participant mentioned their geographical distance from the HEI, making travel difficult, particularly in terms of organising childcare (this presumably related only to the two day residential course, as the rest of the programme is online), which also made it more problematic if students were struggling with an aspect of learning. Another felt that accessing the online material was difficult. One commented that being computer literate was an essential pre-requisite for the programme. Whilst the breadth of the programme was praised, it was also criticised for being very general, and not affording students enough time to 'delve into the learning'. Lack of adequate organisation around work placement, and lack of time with, and guidance from, mentors were two other issues raised, which were particularly difficult for those working shift patterns.

Survey 2

Only six respondents returned a second completed questionnaire, making the numbers too low to rerun the majority of the analyses. However, without exception, all six showed a much higher level of confidence across each of the statements within the competence framework, suggesting that they had gained in experience from both the programme learning, and practice in placement, as shown in Table 8 below.

Table 8: Self-rating levels of confidence in CURRENT practice (n=6)

Competence Statement	Totals for Questionnaire 1	Totals for Questionnaire 2
1: Knowledge for Practice	75	56
2: Partnership Working	50	34
3: Practising Ethically	61	34
4: Care and Intervention	401	261
5: Personal, professional and service development	72	45
Total	656	430

Note: The figures represent the sum of the 6 participants' scores for each competence theme. The categories were scored as follows: 'Confident and already do this competently' = 1, 'Development needed in some aspects' = 2, and 'Development needed in most, or all, aspects of this area' = 3. **The lower the score, the more confident the rating.**

Of note is that one participant was undertaking the SQF7 certificate at the time of completing the first questionnaire, and had successfully attained that qualification and had embarked on the SCQF8 when she returned the second questionnaire.

Section 5: Phase three results of the qualitative study of participants' and stakeholders' experiences of the education programme

5.0 The research population

The total population for this study comprises all programme participants in the first and second cohorts of the education programme for SHCSW & APs in children and young people's health higher education certificate and diploma (SCQF level 7 and 8) programme (n= 32), their mentors and sponsors (senior managers). Cohort one commenced the programme in June 2009 and cohort two in September 2009.

5.1 Sample

A volunteer sample of 15 programme participants, 11 mentors and 6 sponsors was recruited to the telephone interview study during a six month period from November 2009 to April 2010. Programme participants who returned their postal questionnaire and indicated interest in participating in the interview study were contacted by the research team by email and/or by telephone. Subsequently their mentors and sponsors were invited to participate in telephone interviews contact details having been confirmed with the programme participants at interview. The majority of people contacted by the research team consented to participate but a mentor and a sponsor who did not wish to participate gave their reason as 'being too busy'. Table 9 below provides an overview of the study sample.

Table 9: Telephone interview study participants

Research participants	Role	Remit
Participant 1	Support health care worker	Programme Participant, employed in a community role
Participant 2	Family support worker	Programme Participant, employed as family support worker
Participant 3	School health support worker (C)	Programme Participant, employed on Health & wellbeing in schools project
Participant 4	School health support worker (C)	Programme Participant, employed on Health & wellbeing in schools project
Participant 5	Nursery nurse in health visiting team	Programme Participant, employed as Nursery nurse attached to HV team in a health centre
Participant 6	Support health care worker	Programme Participant, employed in a community role
Participant 7	Support health care worker	Programme Participant, employed as Technical instructor for Speech & Language services in schools and nurseries
Participant 8	School nurse support worker	Programme Participant, employed in School nursing service
Participant 9	School health support worker (C)	Programme Participant, employed by Health & wellbeing in schools project-demonstration site
Participant 10	Support health care worker in health visiting team	Programme Participant. Works with health visiting team
Participant 11	Support health care worker	Programme Participant, employed in community role
Participant 12	Support worker	Programme Participant, employed in

		paediatric ventilation support
Participant 13	School nurse support worker (C)	Programme Participant, employed by Health & wellbeing demonstration site
Participant 14	Plaster room support worker	Programme Participant, employed as plaster room support worker in acute sector
Participant 15	Paediatric home ventilation support worker at night	Programme Participant, employed in paediatric ventilation support service
Mentor 1	Health visitor and practice teacher	Mentor for programme participant
Mentor 2	Health Visitor in community health role	Mentor for programme participant in community
Mentor 3	Health & wellbeing demonstration site	Mentor for programme programme participant employed in Health & Wellbeing demonstration site
Mentor 4	Speech & Language services	Mentor for two health care support workers in SLT services.
Mentor 5	Health Visitor	Mentor for healthcare support worker
Mentor 6	Community paediatric occupational therapist	Seconded to transition team for children moving from primary to secondary school. Mentor for programme participant employed as generic support worker for all therapies (OT, Physiotherapy and SLT)
Mentor 7	Public health nurse, health visitor	Mentor for health care support worker employed on Health & Wellbeing in schools demonstration site
Mentor 8	Health Visitor	Mentor for programme participant
Mentor 9	Paediatric acute setting-plaster room practitioner	Mentor for programme participant
Mentor 10	Registered Nurse	Mentor for support worker employed as a Trainer for ventilation support workers-hospital and community
Mentor 11	Registered Health Visitor	Mentor for support worker attached to a GP Surgery
Sponsor 1	Manager	Manager for 5 support workers (4 support workers in acute sector and 1 community based support worker in long term ventilation).
Sponsor 2 (sponsor & mentor)	Manager	Sponsor and mentor for 2 band 3 ventilation carers in paediatric ventilation - community
Sponsor 3	Project Officer Health & Wellbeing In Schools Project Demonstration Site. Physiotherapy Manager	Sponsor for therapy support workers in demonstration site.
Sponsor 4 (sponsor & mentor)	School Nursing Service Manager	School health coordinator, mentor and sponsor for programme participant
Sponsor 5	Project Officer, Health & Wellbeing in Schools Demonstration Site. School Nurse Coordinator.	Sponsor for programme participant employed in demonstrations site (including special needs and mainstream education)
Sponsor 6	Manager, Community Health	Sponsor for programme participant employed in community health

Key: (C) Participation in education programme for SHCSW/APs in children's and young people's health is a condition of employment.

Table 10: Geographical locations of programme participants in study

Programme participants in telephone interview study (n=15)	Location
1	NHS Orkney
1	NHS Highland
5	NHS Grampian
3	NHS Fife
3	NHS GG&C
2	NHS Ayrshire & Arran

5.2 Data collection

The schedule used in the telephone interviews comprised sections on demographical information, the application process, programme content, education delivery methods, workforce planning and perceived impact of the programme on students' confidence, competence, role performance and on the service (Semi structured interview guide, Appendix 4). Interview appointments were arranged in advance and participants' informed consent for tape-recorded interviews was elicited prior to commencing the interview. Permission to use anonymised interview data was confirmed again at the end of the interview. Interviews lasted from 20 minutes up to 40 minutes.

5.3 Data analysis

The interviews were transcribed verbatim and the transcripts were uploaded to an NVIVO 8 Database for computerised qualitative data analysis. A coding framework was developed (Coding Framework, Appendix 5) and the research team undertook line by line coding of the interview transcripts. The results of the qualitative interview study are presented according to the main coding categories identified.

5.4 The research themes

The research data will be presented below according to a range of themes and sub-themes developed during data analysis and with reference to the aims and objectives of the overall evaluation.

5.4.1 Contextual setting of programme participants

[related quantitative data can be found in Tables 4-6]

Programme participants were located in a range of child health, schools and acute paediatric hospital settings; their mentors were generally practitioners who had responsibility for supervising the support worker, and sponsors were senior managers with responsibilities for the services in which the

programme participants were employed. In two cases managers undertook the role of mentor and sponsor. The majority of participants were located in community roles including Early Years Children's Services and Family Support working with public health practitioners, Health and Wellbeing in Schools Project demonstration sites, the School Nursing Service, School Health, Breast Feeding Support, and in technical support roles for Speech and Language and Home Ventilation Services. The participants located in acute services included Plaster Technician Support and Ventilation Support Services spanning acute and community settings. Many of the roles were new or had been recently established, and the roles within the Health and Wellbeing Demonstration Sites were for a fixed term period of two years. The majority of participants volunteered to undertake the education programme when circulated programme information by their managers and programme participants employed in the Health and Wellbeing Demonstration sites were aware that participation was a condition of their employment.

- **Community health roles**

Programme participants located in community health had roles that were still developing; they were expected to work with a range of children and families. A support worker attached to a public health nursing (health visiting) team linked to a GP surgery is the focus in the example below.

...“ our managers met with all the support workers, and they're looking to make the role more universal, so that people are all doing the same thing.... I think the job has evolved, some members of staff allow the support workers to do certain things, and others don't. So the management are looking that if you're employed as a support worker, the expectation will be that you will home visit families, that you will be able to cover all the different topics, if you're getting into a family's home, if they raise an issue with you, the support worker will be able to either find out the information or be able to deal with the situation/issue at that time [but continuing to work under the supervision of the health professional].(Mentor 11)

When a new community based support service was established a senior manager recommended that the newly appointed support workers undertake the [HEI] programme to assist their professional development. Their mentor who coordinated the service referred to issues arising in implementation of the new role and the wider team's acceptance of the programme participants.

" I wasn't sure how the whole process had come about [locally], and who was responsible for them [programme participants]. Because my worry as an ex-HV as well is, these girls are potentially being trained and would be very, very valuable to a HV team, but to my knowledge, there hasn't been any discussion with HVs out there to see if they would be accepting of another skill mix within their team. There have already been issues about staff nurses within HV teams, nursery nurses, now we're looking at yet another qualification working with HV teams...So from the point of view of mentoring them and supporting their learning on this course, it's been quite difficult, and that's because of these organisational circumstances. So, it's not been ideal, but we're kind of muddling through.” (Mentor 2)

This mentor goes on to explain that support workers need to be in roles that enable access appropriate practical experiences to meet the education programme requirements.

"...it was very challenging at the beginning because I wasn't able to offer them what they needed in terms of their hands-on working experience, it was difficult. I also come from a HV background, so I'm kind of reading through all their learning outcomes and everything, and just think this fits in so well with the HV role, and they would get so much better experience if they were sitting with a HV now, rather than sitting with me...I was very conscious of the breadth of what they're doing, and how well it fitted in with HV, but not able to facilitate that kind of learning for them." (Mentor 2)

One sponsor indicated how initial difficulties were overcome.

"I thought I had nothing better to do than to employ them and put them on the course but when we looked at their learning outcomes just by working in our area they weren't going to meet all those learning outcomes so we had to obviously get them other supervised placements so that was a wee bit trickybut nothing that can't be resolved ...do you know what I mean because its such a broad course it would be difficult for any one area to meet those requirements ... we needed other NHS and local authority placements to make sure they were covered ... that provides a better learning experience for the students." (Sponsor 6)

- **Health and wellbeing in schools project demonstration sites**

A number of participants were linked to demonstration sites for the Scottish Government and NHS Scotland *Health and Wellbeing in Schools Project* (SG 2009). This two year project aims particularly to focus on identifying local health inequalities affecting children and young people, their families and their communities, to investigate the particular workforce and training needs of staff to target health inequalities and to apply new integrated models of practice to facilitate the delivery of preventative and early intervention programmes to improve health outcomes for children and young people, further information available at

<http://www.scotland.gov.uk/Topics/Education/Schools/HLivi/health-care/aims>. Support workers within the demonstration sites were informed at interview that participation in the education programme was a condition of employment.

Participants working in the above demonstration sites knew that undertaking the [HEI] programme was a condition of their employment.

"...It was part of, when you went for interview and if you were offered the position, it was part of the thing that you had to agree to – there would be no job offer unless you agreed to go to [HEI] and do this course."

(Participant 9) Another reported *"...a pre requisite of the job was doing this course through the [HEI]."* (Participant 4)

A project lead for one of the demonstration sites (Site A) described the purpose of the project and the funding opportunity that led to the appointment of health support workers locally.

"...I'm currently working as a project officer here in [Place Name] CHP. It's because [Place Name] was identified as a demonstration site for the

Health and Wellbeing in Schools project, by the Scottish Government, and we're one of four demonstration sites... What we're looking at doing with this project, is delivering improved healthcare opportunities to CYP in schools - looking at not more of the same, but a targeted intervention at our most vulnerable groups, looking at breaking down cultural barriers, integrated working, and ensuring there is increased capacity within existing systems. We've been given a quite considerable amount of resource to do that, over a two year period, and included in that was the opportunity to develop the post of Health Support worker, and a generic therapy support worker, and we actually have newly created posts for the period of the project, and it's actually these posts that we have secured the training at [HEI]. So that's where we're at...[My role is] not so much mentorship, more as a sponsor, but saying that, the therapy support worker, she is actually within my team, because when I'm not doing this post, I am actually a [Place Name] [AHP] manager." (Sponsor 3)

The current financial crisis added to uncertainty about assistant practitioner roles.

"...I would like to see the advanced [assistant practitioner] healthcare support worker position being a more permanent part of the establishment, which it won't be at the moment, because everyone is cutting back on staffing, not creating new posts... The pilot project is up until March 2011, with no signs of it being continued." (Mentor 6)

Another sponsor in a Health and Wellbeing Demonstration (site B) discussed the rationale for increasing skill mix by employing HCSWs and APs in this service.

"...I'm a school nurse coordinator for NHS [Name of Board]. I'm one of the three coordinators, so we look at service development and basically lead the team of nurses in [Place Name].[the programme participants], they were employed, not through school nursing, but as part of the Health and Wellbeing project, the Scottish Government initiative, because they're working within the [Demonstration Site B], which is one of the identified four pilot sites. We've got two nursing assistants who were employed, that's them basically just over a year in post. They started the course in September. The two of them are doing it, one's based within special needs education and one's based within mainstream education, although we're trying to get them experience in both fields. So really I'm sponsor for them..."

And what are you hoping that they'll achieve by completing the programme?

I'm hoping that we've got staff. I think it's very clear, the school nurses are band 6, and they're basically doing critical input of work that doesn't require a band 6, so it's just to give us a different level of skill mix. The training can provide these women with the skills that can support the school nursing service and free them up to target their more vulnerable children, like children with complex needs. And I think out of the whole of the project, their model, their remit is the one that has been the most beneficial. I'm really impressed, and I'm really impressed with the two girls as well. They've been well chosen, and they're really motivated and forward thinking, and I think really enjoying this course as well, which I think makes a difference as well...." (Sponsor 5)

- **School Health**

A sponsor who coordinated a school health service cited financial pressures on the service as her rationale for developing the support worker role.

"... I'm the school health co-ordinator for NHS [Name of NHS Board]. There are two school nurses and we cover 23 schools – that equates to roughly 3,400 children. We used to have a school nurse but she had special responsibility for children with additional needs but her funding was ring fenced through the changing children's services fund and that came to an end a few years ago and wasn't renewed. Since then I've been putting forward business cases to try to get a support worker to work with us because obviously it's a huge case load for two people but I always felt that it wasn't necessary to pay a Band 7 and that could be a task that could be undertaken by a support assistant so that's how that came about so the support assistant is funded for 18 months and that comes to an end roughly in July so we are hoping that it's going to be extended..."
(Sponsor 4)

The participant working in this school health service had a number of clearly defined roles, as follows:

"..[The Programme Participant] is responsible for making sure that the screening is done in most of the schools although some of the smaller schools are still done by the other school nurse because she's out there doing other work at the same time. But I'm hoping that [Participant's Name] role will develop – she's helping at the paediatric clinic – she is like a co-ordinator for that. We want one point of contact for the parents and we're hopeful that she is going to be able to get off the island and go to [NHS Board] and see some of the tests and things that are done so that she can then explain that process to parents when they go through that and also some health promotion work as well – not just personal hygiene. She also helps with the babysitting course and things like that. So it's very much a support role doing a lot of work that we'd do anyway, but just being overseen." (Sponsor 4)

A 'Transition Team' was the focus of some developments in services for school age children. Mentor 6 below referred to a new generic support worker role within this service.

"... One of our generic therapy assistants is doing the healthcare support worker course at [HEI], and I am her mentor... I'm a paediatric occupational therapist, and I'm seconded to the transition team as part of this project....[Name of Participant] is our first generic support worker. We have separate OT, physiotherapy, and SLT support workers. I've worked with support staff for a long time. [Name of Participant] is the first one who is going to be generic for all therapies. ... Basically, she has to do a bit of everything, because she could be taking directions from any of the AHPs. So while she is supervised, her line manager is a physiotherapist, she has to be ready to carry out programmes for any one of us." (Mentor 6)

Another participant who had been in post for over a year was employed in a Speech and Language service in schools, worked in school and nursery

settings, and described her role as *"...a technical instructor for speech and language therapy – it's usually working in schools and nurseries..."*. (Participant 7)

- **Acute Services**

Some programme participants were managed through acute services and had roles that focused on particular specialities such as ventilation support and the plaster room.

"... We have five support workers, one who is based in, works in a team in the community, and the other four are all from acute.One of the individual's who is in acute service, she's quite different, she works in a long-term ventilation team, and they're coordinated from the acute services, and are based in acute services, but she herself actually works in the community, but at home with a long-term ventilated child...." (Sponsor 1)

This sponsor in acute services described how local initiatives to develop assistant practitioner roles were linked to the NES developments.

"...Really, it probably goes back to just over a year ago, when I did a piece of work in acute children's services, looking at a capability framework, for the level 4 practitioner for acute services in [name of city], because we had quite an established framework for level 2 and level 3, and we were looking at the level 4. At the same time, [there was other work going on] on the healthcare support worker and [NES Child Health Project Officer] was also involved with that. ... I knew about the tender being put out by NES, because I was part of a team in [Place] that put in a bid as well... at the point where the NES document came out, we had an awful lot of similarities, I think the only thing that was different was the title that we had used. We didn't use the term senior healthcare support worker, because we already had a framework in place, through the SVQ for the senior Healthcare support worker, for Level 3. So we were just looking at the [assistant] practitioner." (Sponsor 1)

The potential for confusion between local and national developments is alluded to in the following comments when the sponsor was asked if the students in his area knew about the NHS Education Scotland Capability Framework:

"...I'd probably say they're not too familiar with the Capability Framework. I'm not sure the candidates are aware of the capability framework, they will be aware of the things that are in their clinical assessment, how that's being used, but I'm not sure how familiar they are with the framework that NES produced overall, for the support workers." (Sponsor 1)

Support worker roles in the ventilation services focused on children with complex needs. The paediatric ventilation service described below had recently undergone changes in personnel that resulted in a change to a participant's mentoring arrangements.

"...But we had kind of inherited her [Programme Participant], because the person who was supposed to be mentoring her took a new job, and we

were new to this job, and we kind of inherited that. I see – so you weren't with her at the start? No." (Mentor 10)

The specific remit of some roles (such as ventilation support and plaster room technician) may have had implications for application of participants' learning and their overall programme experience. The scope of the ventilation support worker role is described by a programme participant below:

"...My role involves working within the hospital and the community. I go into people's homes and take the children to school and stay with them overnight. We just make sure that everything is ok – we do all the [ventilation] checks and we go into all the equipment... we do all the ventilation checks and take temperatures, do the recordings... We are usually on a monthly rota. They try to have us with the same child – for a period of about 6 months to 18 months but that could change any time within that period – you could get sent to other children – it just depends on who needs the care...." (Participant 12)

The ventilation support workers may have had limited opportunities for working with others, and their practice experience was dependent on the care needs of the child to whom they were allocated.

"...I have got a few [working roles] but the one through the course just now is looking after a ventilated child in their own home to let the parents sleep.

Is this for the same child each time?

Yes, I've only got the one child." (Participant 15)

"... Predominantly [care is provided] in the children's home, yes. They both [programme participants] work for the same young person, who they provide overnight care for. She's on non-invasive C-PAP ventilation and has got very complex disabilities. So they both work overnight, caring for that specific child." (Sponsor 2)

Within acute services some participants worked in specific settings and focused on discrete tasks such as applying plaster casts. A mentor for a participant in the plaster room in a Children's Hospital highlighted how staff shortages meant that there was limited opportunity to release staff for education or training and so work based learning was an attractive option. This mentor was confident that there was a future for the role of senior support worker in their department: *"Oh definitely, yes [there will be a role for the SHCSW]."* (Mentor 9)

And a plaster room technician who was also a participant on the programme described the nature of her role.

"... Basically I work within a plaster room so we are plastering, record keeping and we come across a lot of different kind of patients within the area that we work in.

And are you mainly working with children?

Yes, it's children that we work with, well, up to the age of 13 but some of our long term patients with disabilities – their care is continued so we can have patients up to say 17 years old." (Participant 14)

The variation in the types of workplaces and roles described by the participants and stakeholders above indicates that the education programme aimed to prepare SHCSWs and APs for a wide range of acute, school and community/ public health settings. Participants were employed in recently established posts such as the Health & Wellbeing in Schools demonstration sites, breast feeding support, and speech and language support, whilst others in the acute sector such as the plaster room technicians and some in public health were located in longer established health care support worker roles. There was considerable variation in the types of client groups addressed by the HCSWs. Some worked with children within a narrow age range whilst others worked with a broad age range. Participants also differed in the type of experience they had with the client group prior to commencing the programme with some participants (such as a breast feeding support worker) reporting limited healthcare experience compared to others who had extensive experience in work with children. There was variation also in the amount of hours per week worked by participants ranging from around three hours per week up to full time employment.

For the majority of participants undertaking the programme was optional but not in the case of the Health & Wellbeing in Schools project where participation was a condition of employment. The latter were employed in fixed term contracts for two years whereas the majority of participants were employed in substantive posts apart from the breast feeding support workers who were volunteers working up to three hours per week.

Some participants reported clearly defined roles and responsibilities, as in the school health service, whereas for others the roles were still being developed, for example, a recently established breast feeding support service. Based on participants' descriptions of their roles it appeared that some tended to work in fairly isolated roles, as in the case of the ventilation support workers who cared for children in their own homes at night, and others were more obviously integrated into multi-professional teams within their day to day work (School Health Service, Speech and Language in Schools Service, Public Health) thus having access to a range of professionals. In some cases the roles focused on specific tasks that required completion, such as applying plaster casts or undertaking ventilation checks, whereas in other settings the holistic nature of the roles was more evident in participants' descriptions of their work, as in public health, the Health and Wellbeing in Schools demonstrations sites, and the school health service. The nature of the relationships required of the participants also varied in scope: In some cases the caring encounters focused on episodes of care delivery whereas for others more sustained interpersonal relationships would be required. In all settings there was recognition that, with appropriate preparation and supervision by registered practitioners, senior healthcare support workers could undertake some tasks and roles previously undertaken by registered practitioners and these could have potential cost savings.

5.4.2 Recruitment to the education programme

- **As a condition of employment**

Participants were either circulated information about the programme by their managers or participation in the programme was a condition of employment as previously noted in the Health and Wellbeing (H&WB) in Schools Project demonstration sites. Participants were circulated information by their managers and often had limited time to consider their decision before submitting their applications. Those in the H&WB in Schools project demonstration sites were informed at interview that there would be a requirement to attend a university programme. Mentors similarly had limited notice of the education programme starting and frequently their first contact was when they were assigned programme participants for mentorship.

Within the Health and Wellbeing in Schools demonstration sites information about the education programme was not widely known in advance of support staff being appointed.

"No, I didn't [know about the programme when it was in the planning stages]. The first we knew about it was when our therapy support staff were offered a place. [Programme Participant] is part of the Health and Wellbeing in Schools project, pilot study, and as part of her job, she was promised a place on the HNC course... it was part of accepting the job that they would go on the programme." (Mentor 6)

The following participant in a Health & Wellbeing in Schools Project demonstration site reported that she had not been considering a two year university programme and was surprised to find herself in the student role. When asked how she came to be on the programme she reported:

"It was part of, when you went for interview and if you were offered the position, it was part of the thing that you had to agree to – there would be no job offer unless you agreed to go to [HEI] and do this course. And when asked if she wanted to go to university she stated "No- definitely not. I think because when I went for the job it was not advertised as what we would be doing – there was a little bit to say that you will be doing something at university – not a two year HND course, so I feel I was a little bit hoodwinked into doing it – I have to be honest that way." (Participant 9)

- **Applying for the education programme**

Some participants reported that the application process had been very quick following their manager's recommendation that they should do the programme. Participant 1 suggested that the decision to undertake the programme was sudden and may have been too quick because their service was new. *"...So I don't know if we jumped the gun a bit to be recommended for this course because it was our manager who suggested it for us."* (Participant 1)

The application process for the education programme appeared to be fairly straightforward with potential applicants asked to indicate why they wished to undertake the programme.

"...The details were forwarded on from management to the health visitors I work for – they printed it off and gave me a copy of it. It was just an application form. We had to write why we were interested in the course and how we thought we would benefit from it." (Participant 10)

One participant with an administration background was keen to work part time in a newly established support worker role and saw the education programme as an opportunity to develop a healthcare career.

"I applied for a [type of community] support worker role that is actually being managed by someone who manages me here within my improving health team in my admin role. She thought it would be a brilliant thing for me to go on. I thought that sounds great, I want to develop myself and I want to move in a different direction from office based work. Well it was a really short timescale for getting applications in and for the course to start – I think it was within a month. We got ours in ok because our manager said 'yes, we'll support you' so it was due to start in the March but it started in the May and we heard fairly quickly that we were on it because it was such a short turnover from the application getting submitted and the class actually starting." (Participant 11)

Although selected by line and senior managers the participant below, in common with many others, did not have a clear understanding of what would be involved in the education programme.

"I heard about it [the education programme] through my team leader – she sent me a letter and asked us if we would be interested and then we had to send in a support statement to the education department within the hospital to [senior manager] and after that, he chose between three of us who wanted to do it.

So did all of you manage to get a place on the programme?

No just one of us...Yes I was pleased....Although it was a practitioner's course – I didn't really know what I was going into to be honest – I didn't know what it actually meant. I had just finished doing the SCQ and I just thought that it would be a progression so I thought I was just going to take it." (Participant 12)

The speed of the application process through to acceptance gave participants little time to prepare for their studies, but even so many considered this a very good opportunity .

"...[the application process was] a bit of a whirlwind at the beginning - I didn't think that it would be that quick – as I say we heard within a week that I had got a place and I think it was two weeks after that that we went for our two day induction...To be honest I would say that I wasn't really looking for anything, but I am glad that it came along and when I was offered it I thought that it would be a good thing to do." (Participant 1)

Some participants recognised that if they postponed undertaking the programme the opportunity might not be there in the future.

"...I actually only had two weeks to do my application form. Because I had been asked, and I hummed and I hawed, and couldn't decide and thought I'd leave it to next year, then thought maybe I will do, then finally I had decided I would try for the course, so I actually only had two weeks to send my application form in before I went to [HEI Location] for the first day." (Participant 5)

In contrast to those who hadn't been planning to undertake further study the participant below had declared her goal of returning to study and found out

about the programme when she was reviewing her working hours with her manager.

"...when we were discussing hours I said to my line manager that I would like to work all my hours, I'm only part time over a Tuesday, Wednesday and Thursday and that would leave me two days a week for studying because I wanted to go to college to do something. She said – oh there's a course that has come up that you might be interested in. It all fell into place and it was perfect for me, I couldn't believe it. I put in an application form and they contacted my references and then I got a letter confirming I had a place on the course." (Participant 6)

Sponsors described how staff were nominated and subsequently selected to undertake the education programme.

"...Yes, what we did within the selection process they went through, was that when the course became available, I had contacted [Lecturer] from [HEI], and asked what the university selection criteria were. And then I put out an email to all the lead nurses and head of nursing, about the nominations that we would get, and 10 staff in total were nominated. They were all asked to put in a brief summary CV, and a statement of support, and we selected from there, and we used the same selection criteria that the university applied, with regards to study in the past five years, and having their SVQ Level 3. So we applied those criteria, and that is how we selected the five that we have." (Sponsor 1)

"... I think it was some time ago now, there had been an email come around, from [HEI] and that had highlighted the course availability, and that there could eventually be some kind of sponsorship, and would anybody be interested. So I put it out to the team that I manage, and we had quite a lot of interest, and ultimately we had the two people who were successful, taking up the places." (Sponsor 2)

One of the sponsors heard about the programme through a contact at the HEI where she was undertaking postgraduate study.

"...one of my tutors is [Education Manager at HEI] who has been involved in setting up the programme – it was him who suggested it to me and then I applied to NES for the funding to try to get [Name of Participant] on the course – that's where it came from." (Sponsor 4)

Sponsor 6 was informed about the programme via the Lead Nurse in the NHS Board, whilst sponsors 3 and 5 were project leads for two of the Health and Wellbeing Project Demonstration sites. The latter had indicated that participation in the education programme was taken in to consideration at interviews for prospective support workers posts. *"... Yes, they were newly created posts. And we saw this as an opportunity with the support of the Scottish Government to facilitate some dedicated training to these posts...all of them were really keen to undertake the training."* (Sponsor 3)

Generally participants had a limited period in which to decide if they wished to participate in the education programme. It is possible that decisions about participation in the programme were influenced by the short time frame for receipt of applications. Mentors similarly had limited prior knowledge of the programme, in the main had not been involved in planning for the education

programme and took on mentorship at short notice. Sponsors of participants had been notified about the education programme during the planning stage and subsequently forwarded programme information to all line managers from NHS (E) Scotland and the HEI delivering the programme. Programme participant numbers recruited to cohort one were small (eight students following the withdrawal of four within the first month) compared to cohort two with 24 students; the increased time for recruitment to cohort two included acute sector support workers.

5.4.3 Academic background of participants

Participants varied widely in type and level of academic qualifications held and in how recently this experience was obtained. This is also reported in the phase two survey results. The majority of participants irrespective of academic background appeared to be coping with the demands of the programme. Some participants who did not have academic backgrounds struggled with the academic level of the programme whereas others with similar academic histories had apparently been able to cope with the academic requirements.

"I think she found it OK. I do know one of the other students who is doing the course, and it is many years since she did any academic work, and she found it quite challenging." (Mentor 6)

"I think she's very very keen to do well. She hasn't got an academic background that I'm aware of. And the transition has been very good for her. I think she's quite an able person. She's maybe not had the background, sitting courses and doing things in the class, but this could probably lead her into further education." (Mentor 11)

A few participants had not studied since leaving school, with one saying.

"...I've never done any studying before either – just at High School and that's the last time I really did anything." (Participant 11), and another reporting *"...I hadn't done any studying since [1980s] when I sat my higher in school. I didn't go to university which was a big regret of mine. I hadn't written an essay since then."* (Participant 6)

Some worried that their academic profile would rule them out of places on the programme, but they had still been able to secure a place: *"Yes. I did worry that they would have me [on to the programme] because it's about 30 years since I did any studying of any kind!"* (Participant 3). Other participants had undertaken further courses but not in subjects that were directly relevant to the current programme, for example Participant 10 stated *"... I did courses when I was younger, but they were more in the administration field."*

In contrast a number of participants had recently undertaken study in courses directly related to child health. When one participant was asked if earlier study had involved information about child health or children's health nursing they replied *"Yes – a lot of it was about legislation so I did quite a bit on that when I was doing my SVQ. I had also done an HNC on health and social care."* (Participant 12)

A further participant with recent academic study accessed stage two of the programme (HND, SCQF Level 8) rather than repeating previous work citing recent relevant study as the rationale for this decision:

"I have just completed my PDA in early education in June so I felt that I enjoyed doing that – it was a year and a half and I felt that it would be best just to continue with my training and so I thought I'd just go for it. I had a look through all the stuff and thought it would be good for this type of post and I thought this would really help in my current role...I'm actually on the second year – I got onto the stage two because of prior learning because I got my PDA and HNC and all that so I think that has been the right decision because I feel I would have been going over old hat if I went into Stage 1." (Participant 2)

The above decision was in contrast to another participant who elected to undertake both certificate and diploma level programmes at the HEI despite being eligible to go straight in to the level 8 (SCQF) diploma. *"...No I'm doing the whole lot. I could have had the chance to go into the second year but I chose to start from scratch...because it's been four years since I have done my HNC."* (Participant 8)

Those with a recent history of relevant study considered this to be advantageous.

"...I'm enjoying studying – I did an HNC a couple of years ago in social care and I have to say that has helped with doing this." (Participant 4)

A further group of participants had completed nursery nurse education programmes.

"...I did my nursery nurse course about three years ago – just finished doing that at [Name] College so there has been a gap of about a year and a half to two years between the courses – not too long..." (Participant 7).

Another nursery nurse had studied in the past, was currently working in a community role and was *"...now working as part of a Sure Start project, helping health visitors within the community with vulnerable families and my background is – I've got the NNEB which is the nursery nursing course..."* (Participant 9)

A small minority of participants already held degrees, or had experience of studying, and according to managers were coping well with the academic study.

"...I think we were lucky enough to get five members of staff that had all at some point in time, studied to quite a high level, a couple of them have degrees, so they weren't particularly challenged by being in the university environment..." (Sponsor 3)

Readiness for academic study was highlighted by some sponsors.

"I think they were both ready [for academic study] and I think it was very obvious at interview that they were both ready for further development. One was a classroom assistant, and one worked within the school setting as well. And it was very evident that they both needed new challenges. And they were up and away, and I think they've just relished it, and

they've both got 'A's for their first module. I think they're just thriving on it..." (Sponsor 5)

A sponsor in the acute sector stated that their participants were at SVQ level. The range of academic backgrounds in acute sector participants appeared to be narrower than that seen in other locations.

"Well, all of ours have done SVQs previously, so they've been used to working within competency frameworks, and certainly there are three of them that have done their SVQ3 relatively recently, so they've been used to using that kind of competency framework, and also some of them have undertaken local programmes, so they've had the competency assessment, but I'm not sure they're really that aware of the NES framework." (Sponsor 1)

5.4.4 Motivation for undertaking programme

Programme participants were motivated to undertake the programme for a variety of reasons, some of which were general and others more specific. Typically, reasons fell into three broad categories. These included; the perceived opportunity to develop or extend their current practice, to gain more in depth knowledge to inform their child health practice, or to gain a qualification whilst working and hopefully to progress to a Band 4 position. These motives were collectively identified by the mentor below.

"She [participant] was hoping to widen her experience, and her qualifications, so she could work with a wider range of ages, and have a bit more in-depth knowledge as well." (Mentor 6)

Although personal learning for its own sake was seen as valuable, the advantages of gaining a qualification were also seen in general terms by these participants

"Just personal learning really and if opportunities come up in the future I would be qualified to go ahead and do that." (Participant 7)

"I'm just looking at it as a great opportunity to get a qualification, hopefully, and be working as well." (Participant 4)

"...When I first found out about the course, I solely wanted to do it to get more knowledge and skills in the role that I am doing, but certainly you kind of think, you know, what could it open doors to?" (Participant 10)

For one participant simply having a new challenge was important.

"...What spurred me on? Well, I think I was getting a bit staid – I just needed a change and I thought to myself, if I don't move now, I'm going to be too old and nobody will want me..." (Participant 13)

Some participants were more specific about the advantages of the qualification. One of the main incentives was to progress up the NHS Careers Framework to a Band 4 position. Some hoped to be able to enter nurse education on completion of level 8 (Diploma).

"..I thought it would be really good to get a qualification. I thought it would perhaps be good for promotion." (Participant 13)

"I have been told that by doing this course, it's like a stepping stone. Hopefully after doing this course, if there was another course that would lead me on to being...a trained staff nurse – I would probably go on to do something like that." (Participant 14)

Entry to nursing was seen as a feasible goal by one mentor when considering potential options for participants upon completion of the Diploma.

" I don't know if it would take them forward into a nursing course, I don't know. They're going to have a diploma at the end of it, and it would be up to them to choose. whether they would go on to do a nursing qualification I don't know, but it's a possibility. ...and the amount of work, I don't think it would be a three year nursing course they would need to do, obviously they would transfer into the course at whatever stage, I think." (Mentor 3)

Qualification was also seen as providing a way of developing and expanding practice within current roles. This advantage was noted by one of the ventilation support workers, who recognised that the preparation she had received for her role to date focused on the specific ventilation checks and observations she was required to record, but was keen to gain wider knowledge and to develop her role further

"What I was hoping to achieve is - I do think that the knowledge would be good. It gives you an insight and its more education because we really only get taught about ventilation and the checks. It actually gives you a bigger picture on what goes on and although a lot of things you are actually doing – you never really thought – it makes you think about what you are doing as well. I may be able to expand my role within the job." (Participant 12)

The advantage of role development is also referred to by the following participant.

"I was just interested to know about the child health and well being side of things. Something - more of an insight into things instead of doing the same things day in and day out." (Participant 15)

Some participants signed up to the education programme without having a clear understanding of what this would entail.

"No - there were things that [Manager's Name] got us to sign and after we had signed them I didn't realise what it entailed properly because we were never really told." (Participant 15)

From the manager's perspective the funding available for participants to undertake the programme was a definite incentive for sending staff on to the programme.

"I think a big bonus was the fact that it was being funded. And I think if it wasn't funded, there would have possibly been less of an uptake. I mean, there is that commitment to travel, accommodation and training – these are all things that [are a] golden carrot at the moment." (Sponsor 3)

5.4.5 Mentorship of programme participants

A key component of the programme was the allocation of a mentor for each participant (Participant questionnaire responses relating to the mentoring process can be seen on pages 56-59). Results from data analysis indicate that the majority of respondents had positive experiences of mentorship. Mentorship was explored from the perspective of sponsors, and mentors themselves, as well as programme participants. The telephone interviews with a sample of programme participants, mentors and sponsors explored strengths and limitations, and recorded positive feedback and areas for improvement. Analyses of emergent themes and categories are presented below.

Several of the mentors and programme participants made comments regarding access and technical difficulties at the start of the programme, but for the majority, these could be viewed as 'teething problems', and were resolved throughout the duration of the first programme.

- **Mentor selection**

There was no one standardised route to mentor selection, and a variety of selection routes emerged. Mentors were generally allocated to programme participants by senior managers in the placement areas. Other routes included identification of the health professional in post as the most appropriate, because of current or future working relationships, experience and accessibility. These selection decisions were taken either through discussion with potential mentors, or in some instances, without discussion. This sponsor comments, *"senior staff have identified mentors for them, which was beneficial, and we've tended to go for people who are already experienced mentors"* (Sponsor 1).

Selection of mentors was also contingent upon existing organisational structures, at workplace or Trust level. For instance, two sponsors were also acting as mentors. Additionally, continuity of mentorship could not always be assured, owing to staff turnover. On at least one occasion, the programme participant themselves directly approached a health professional to ask them to be their mentor. In consequence of this variability, preparation of mentors for this new role was not always a straightforward process.

"Yes, it was very challenging at the beginning, and I think, because I wasn't able to offer them what they needed in terms of their hands-on working experience, it was difficult. I also come from a HV background, so I'm kind of reading through all their learning outcomes and everything, and just think this fits in SO well with the HV role, and they would get SO much better experience if they were sitting with a HV now, rather than sitting with me. From that point of view it's quite frustrating for me, because I was very conscious of the breadth of what they're doing, and how well it fitted in with HV, but not able to facilitate that kind of learning for them." (Mentor 2).

Some programme participants mentioned that they were required to provide the HEI with the name of their mentor.

- **Preparation and planning**

For some mentors, the process for finding out about the programme had been unsatisfactory, particularly in the case of those who were not able to attend the two day orientation residential course at [HEI]. A suggestion from one of the mentors was:

".... if [HEI] could organise a mentors' session, centrally, and not just in [HEI base] ... They did say that they would have options to come and visit us, and to have one-to-one chats with them, and all my details were passed on to them, but they were never in contact, and that has never been arranged" (Mentor 2)

One mentor had not been contacted prior to taking up the role, and another was visited by one of the tutors, but not until after the programme participant had commenced the programme. Another mentor took the initiative in finding out as much as possible about the programme being undertaken and made it their responsibility to identify expectations around mentorship. One experienced mentor commented " ... *I do enjoy having students, and I enjoy the learning process. But this has been difficult because it's not been clearly laid out, what the expectations are*" (Mentor 1).

It seemed that many mentors would have liked more information about the programme, the learning outcomes, the placement requirements, how these all linked together, and identification of who was responsible for what, but it was acknowledged that on occasion, organisational issues in the local workplace made the whole process more difficult. Even where processes were in place to orientate and prepare mentors, factors such as annual leave, distance from the HEI and timing prevented some mentors from taking advantage of them.

- **Roles and Responsibilities**

Other mentors were able to access information about the programme, but were unclear about their role, as evidenced by the following mentor; *"we all have a different idea of what our role is"* (Mentor 9). One mentor mentioned that she had been given a Mentor's Handbook, with contact details, in the event of any concerns. Some mentors directly accessed electronic programme materials from *Campus Moodle*, while others relied on their programme participants to provide them with information in general " ... *because really the information that my mentor is getting is through myself ... they don't know exactly what they should be doing*" (Participant 10). *Campus Moodle* was not universally accessible, and on occasion, failed to provide up-to-date modular material. One mentor had sought information through her student, but had also found it very beneficial to meet others in her work area who were mentoring programme participants on the programme, as they were able to discuss the documentation and their mentoring role. Another mentor who did not have this support indicated that it would have been valuable.

There was some confusion about the responsibilities of mentors. The HEI expectation was that mentors would focus on the practice experience of programme participants, as interpreted by the following mentors:

"...it's just talking through different situations, explanations, and if there's anything she's not comfortable with, to just work through that together. I

think that's my main role. And to make sure she's got her paperwork, and she's achieving the objectives she's got on her paperwork so she can take that back to the university and display she's doing what she needs to, to get the qualification." (Mentor 7)

"I haven't done anything on the academic side. I've discussed how they've gone around doing their assignments, looking at the evidence for fulfilling the different aspects of the course, the feedback sheet that you have to fill out, we've gone through that in quite a lot of detail, and discussed what aspects of their job fulfil that, and what extra information they've needed to be able to succeed in those particular criteria." (Mentor 4).

Some programme participants were also quite clear that the mentor's role related to the student's practice:

"I prefer not to use my work mentor for [HEI] because I'd rather have people who know what they're talking about ... I mean, I'm using my mentor within the workplace for day-to-day working ... to make sure my role is fitting into the team. But when it comes to the [HEI] work, at the moment I'm not needing to rely on that service." (Participant 9)

One participant mainly accessed her mentor to discuss and sign off her learning outcomes, and in the same vein, one mentor commented

"My role now is more about looking at what they've gained from these placements. So sitting down with them afterwards, and saying right, which of these learning outcomes have you met in that placement, and which ones have we not covered yet?" (Mentor 2)

However, a sponsor noted some mentors regarded their role as supporting the programme participant in their academic work, in addition to focusing on the practice portfolio. This was evidenced by the actions of some mentors, who also took on the role of academic support for programme participants' written assignments, *"we go over all the written assignments as well"* (Mentor 5). In addition, some participants saw it as appropriate to access their mentor for academic support, e.g. for assignment work.

"...When I did my first two essays, I let her [mentor] read them, and she said fine ... send them ... I said it [third essay] would be delayed because my mentor was on annual leave and she wanted to read it, and I was told by Uni that I shouldn't be bothering my mentor with that.... Well, I thought that was the idea of having a mentor to read over your stuff ... give a wee bit of guidance. They kind of said, well you're not meant to be bothering your mentor, letting them read your work. She offers guidance, but she doesn't know how far she should be offering the guidance." (Participant 5)

- **Arranging Placements**

For some mentors, arranging placements for programme participants was seen as part of their role,

"And [Name of programme participant] has more or less finished her placement, so I was able to sit down with her last week, and she'd identified a couple of things around mental health, that she's now made arrangements to go on a placement with someone from the CAMHS team here, and I've arranged for her to go and spend some time with a HV health colleague." (Mentor 2)

Conversely, one participant observed

"We did have a couple of meetings with [Mentor] at the start – she was going through it [course material] and she was a bit concerned about how we would meet some of the objectives in our work ... it seemed that nobody in our workplace was taking responsibility for our learning or development - the mentor or our personal tutor she said "oh well the arrangement of the placements isn't up to me." (Participant 1)

For those mentors who saw it as part of their role, placement allocation had the potential to be problematic, due to a narrow range of available placements and work settings for certain participants.

5.4.6 Contact time with programme participants

Allocated time and frequency of contact were quantified in the participant surveys, and can be seen on pages 56-58. Sponsors, mentors and programme participants were asked, by telephone interview, for their views on contact arrangements.

Unsurprisingly, the proximity of the programme participant facilitated contact time with mentors, as illustrated by this quote:

"Well, where I am now, [Participant] works 20 hours, and she's based in my office, so I see her three days a week, and she gets a fair amount of time to do her university work, and I'm quite up with what she's doing, because I see her all the time. But the other girls sit within the team, and one works 7.5 hours with me, and the other one only works five hours with me, so I see very little of them". (Mentor 2)

"... the ongoing support just when we see our mentor just through normal working days and we're also able to contact her at any time if we have any queries with anything and it works really well". (Participant 7)

"I actually see [Name of Mentor] everyday I am at work. We speak about uni stuff and if I need any advice, she's there. Last Thursday we sat and signed a lot of my stuff off and I showed her what theory I had for it and talked about what placements I had been on and what I had gained from them." (Participant 6)

Such proximity often facilitated informal mentoring arrangements, as evidenced by one participant who accessed another health professional frequently because she worked beside her, rather than setting aside time with her allocated mentor. Other mentors, however, clearly saw the need to set up and hold formal sessions with their programme participants. There was no clear pattern to these arrangements, as they were often dictated by role, workload. Mentors saw as sufficient anything ranging from an hour a week, to an hour a fortnight. For some, specific meetings were set up, with the opportunity for additional contact if and when required.

"Well we had three appointments made for a mentoring session to go through the pink book but apart from that it's an informal arrangement– if we want to have a chat then we can phone or email her or we can meet up with her at work". (Participant 11)

Mentors saw contact time with participants as important, and part of their role, *"We have specific time, we do make specific time, and it is part of my role, and I'm expected to do it, so it's within everyone's working day"* (Mentor 4).

- **Ongoing support for mentors**

As one sponsor commented,

"... I think it's important that the mentors get support as well, because it can be quite challenging, and it's an additional work commitment. I think it's definitely the way things are going from a learning point of view, and something that we shouldn't be surprised to be seeing more and more. But I do think we have to make sure the mentors are getting the support, both from [HEI], and also from employers, making sure that they have enough time to undertake this work, and value it for what it is". (Sponsor 3)

Experience of being a mentor varied greatly among those interviewed, ranging from those who had never mentored before, to others who had extensive experience of mentoring other students, e.g. nursing students. This in turn led to differences in their expectations of support, both from their managers and colleagues, and from the HEI. One mentor commented that although she had not received preparatory materials from the HEI, her prior experience of mentoring prompted her to examine the requirements of the programme with the programme participant. The language and format of the programme documentation appeared consistent and easy to understand, particularly for some experienced mentors. On the other hand, *"I really have never mentored anybody with no support before, and I'm not sure exactly how this programme is and really what is expected from the students"*. (Mentor 1).

One mentor found mentoring similar to that within student nurses' programmes, and another, drawing on her experience of mentoring student nurses, found it easy to understand what she was supposed to be doing, and assess what level the programme participant was at. This was mirrored by a participant who said:

"I have every confidence in [Mentor], and I felt she's done a lot with student nurses coming in, she's got another one coming next week, she's been a nurse for a long time, for 12 years, and she's done the degree course, so she's pretty experienced." (Participant 3)

"...so far I think everything has run very smoothly and I'm happy with all the mentor and support from the university and things so I would be happy to do it all again exactly the same way." (Participant 7) *"We did have a couple of meetings with [Name of Mentor] at the start – she was going through it and she was a bit concerned about how we would meet some of the objectives in our work. Just because there is such a wide span of different subjects and issues, and certainly from a [focus of programme participant's work] point of view, they are not really relevant to that sphere of work."* (Participant 1)

Another factor raised by two mentors that could facilitate the mentoring process was prior knowledge of the participant, and their capabilities, as they

were previously employed in the workplace. However, one mentor qualified this by raising concerns about objectivity of judgement.

One mentor with experience felt strongly that mentorship was made more challenging by the lack of clear information, programme details, explanation of the mentorship role, and what was expected of the programme participants, as she has been used to this degree of orientation in the past. Despite electronically accessing programme information, and being shown information and guided by the participant, one mentor felt it was *"a bit of the blind leading the blind"* (Mentor 10). In one Health Board, participants and mentors met with one of the HEI lecturers, to answer specific questions. Although mentoring experience and skills can be seen to be transferable, it was apparent that information and guidance about both the new role and new qualifications were a priority for all concerned.

As the programme commenced, and the participants became more conversant themselves with its requirements, their dependency on the mentor altered accordingly:

'...my mentor is always saying, I hope I'm being supportive enough to you. I know some of the other girls have struggled with their mentor but I think – well what are the expectations really? As long as I am getting on with the work and I'm doing it, and I'm sitting down and meeting with her and she is going over everything with me. I think there is more of an understanding this semester of what is expected of her because I will understand it a wee bit better and you see where all the paperwork fits in within the portfolio learning.' (Participant 10)

"No – they didn't really know what the mentor role meant and it wasn't very clear. I think they've got a clearer picture now." (Participant 12)

Participants referred to the support received from mentors and the efforts they made to understand the demands of the programme.

"I can't really speak for the others, but to be fair to my mentor, I think what made a difference was that, we had skimmed through it, if you like, and I know that my mentor has been a mentor for student nurses, so she was quite up to speed on what was expected and that, but I think when she, what I noticed was that there was a difference in what I got to do at work, when she actually sat down with me one day away from the office. We'd been to a meeting and then we went and had a working lunch, when she sat down and went through this clinical document, the pink thing that has to be filled in, I think she then took a bit more on board, gosh we need to get you doing this, this and this." (Participant 4)

"My mentor is really interested in everything that I've got, and she's always like bring it in, let me see it and I'll have a read through, and if there's anything I can help you with – she's very hands on, and will do as much as she can to help you." (Participant 5)

5.4.7 Processes for students who fail to achieve

The issue of the failing academic student was rarely mentioned by mentors possibly because managers had nominated existing members of staff or

recommended staff recently appointed to new posts. Arguably managers may have had less knowledge of participants' academic strengths and limitations. One mentor thought that the reporting system for failing SHCSWs was unclear compared to the student nurses' reporting system.

"...With a nursing student, you have a clear line of action, you'd know what to do with a nursing student and cause for concern....But I could see where it could become an issue, and maybe someone, what they think their capabilities are could be completely different to either academically, what they can achieve, or some people are very maybe good academically, but when it comes to visiting families or communication skills, that's a different issue altogether. But there's nothing like that with this particular student. And I'm not quite sure what the plan is for the future for [NHS Board]. That hasn't been discussed in any great detail with HV staff." (Mentor 11)

Other mentors, when asked, identified occasions when liaison with the university would be important such as if a student became a cause for concern.

"Any other times you think it would be good to liaise with the university? I'm thinking about the student nurses' programme again, I think at the beginning would be very useful. But [Programme participant] is a very good student, and I couldn't ask for anyone better. But if I had someone that I was having problems with, that was a cause for concern, if I did have a cause for a concern, then it would be quite useful to have contact with the university." (Mentor 8)

5.4.8 Programme organisation and structure

Generally the programme content was meeting sponsors, mentors and participants' expectations. Two sponsors described the programme as thorough and very up to date.

"...Just listening to the girls, as I say, I've not had much to do with it, but in reading, and the content of the programme, I think it's very thorough. They do more child development than the school nurses probably will do. So I think it's going to give them a really good grounding on normal child development, and then abnormal. I think the focus is on parenting and positive parenting as well, will be beneficial. And the basic roles that they've got in supporting CYP could be huge. But I think as well, I think that when they come to writing about the literature, that's a new concept for them, but I think they've addressed that really well and got over that. And the learning and the knowledge gained has really been quite high." (Sponsor 5)

"...The focus on early years is a good thing and certainly I think the course was very well designed – it went through everything about child development. All the stuff that was coming up like growth chartseverything was bang up to date and they knew all about the strategies [for Early Years interventions]." (Sponsor 6)

Participants gave examples of how the content covered was increasing their knowledge and understanding of complex issues such as resilience, culture and diversity and equality.

"...Well we are talking about holistic care and we were talking about religions and cultures. It's something that you don't really know a great deal about and I feel that's had an impact on me...we've been covering resilience and we've looked at various reports and parenting skills. We've been looking at culture and diversity – within that we've been looking at equality – I think we could have done a bit more on equality. Sometimes it's difficult to know the difference between equality and what equality really means within the health service in delivering a service so I thought maybe we would have done a wee bit more of that." (Participant 12)

Another participant thought she was gaining a different and richer perspective on working with children and families

"....all the things about consent and ethics and just the general learning that is coming out of it, I do think it's great and worthwhile, and really interesting so I like doing all that and yes, it does come in handy. Your knowledge is forever increasing so you can apply it to different children, different families and different people. ...Even things that I wouldn't have considered, because I didn't do a public health course, it just makes me think of things in other ways, e.g. child protection issues and things like that – I wouldn't have looked at them as much if I wasn't doing this course, so in that way, yes, it's completely worthwhile." (Participant 1)

One participant had initially thought that the programme and her practice role were completely unrelated, but was now beginning to understand the relevance of the programme content.

"...It's beginning to fit much better. I think initially it seemed like "goodness me what are we needing to do this for", what we are actually doing, but I think because it was a new role I think everybody is trying to find their feet with it in that the school nurses have not had this kind of support before, and there has been a lot of changes in school nursing as well, so initially there it seemed was a lot of disparity between the actual course work and what we were actually doing, and I think my three colleagues in the same situation all felt the same. But it's now beginning to marry much better, and I am anticipating that will be even more so as the course goes on and as the role develops and we settle into our roles." (Participant 4)

Where participants could identify a learning need they were grateful for advice from professionals who were frequently able to suggest resources.

"I'm part of the improving health team so the health promotion officers have been really good in pointing me in the right direction. We're doing a culture and diversity part on it and I went to one of the health promotion officers to ask the best place to get information and right away she pointed me to a place called [Name] to a [Name] and she told me to come in that day and she arranged for me to go and see a couple of Asian families and go to nursery to observe a wee boy and join in with him at play to see if I could see any differences to the way he played in relation to other children because I was doing an essay on it. So everybody has been really helpful – it's just a case of asking." (Participant 6)

One participant commented there had been some repetition of material.

"...it is good – there's a lot of learning in different areas. I do think it's good – there are some bits of it that are quite repetitive – like in second year – we've only really just started second year, so I haven't got right into it, but I do find there are bits of it that are repetitive – like the religion and diversity part – there was a big chunk of that in first year and in second year as well..." (Participant 14)

Mentors appeared to view the programme content as relevant when it matched the role of the student in the workplace, it offered breadth of content and was flexible enough to allow in depth exploration of specific issues even though mentors had limited preparation about the programme

"...Well, we've been through the first bunch of paperwork together. I know the course is a developing course, it's a new course that's, em, I think it's been looked at a lot, by the students going through it, it's a bit of a learning process for everyone, but from the course materials, I think it was pretty clear as to what they were trying to get the students to achieve. And the areas of practice that were to be looked at and studied are very clear. I think that the information that we got from the course, the student and I, well, when you first read it, it took us a little while to get our heads around, well, certainly for me, because it was brand spanking new, but after sitting with [participant]] for a couple of sessions and getting our heads around what she actually had to do, it was fairly clear what path she needed to take. So far so good." (Mentor 7)

Participants with prior experience were able to draw on this to constructively organise their learning.

"...There's quite a lot that's repeating on what we learned at [Name] College as part of our childcare course but having said that, it is more in depth and there is a lot a new things to learn as well. I suppose it's maybe a better way to do it this way because it's already familiar course work so it's fairly straightforward. I don't know about how the diploma is going to go but at the moment there is a fair bit of repetition." (Participant 7)

When mentors were asked about particular strengths of the programme child development was cited.

"...Well, I think she comes up with a lot of knowledge about child development, so I think that's a strength of it. So it's linking up her previous knowledge with what she's learning in this new practice." (Mentor 8)

The educational content of the programme in the opinion of one mentor compared well to in-service training because the programme offered opportunities for more in depth exploration.

"...I think the course is giving them a lot, it's looking much deeper, in-service training looks at it, but just in a topical way, looking at individual topics, it could be child protection, it could be domestic violence, whereas I think the course is looking more holistically at families and situations, and society and communities and things like that, which I think gives the student a more in-depth understanding." (Mentor 11)

When mentors were asked to comment on areas that the programme did not address in sufficient depth they referred to omissions linked to specific client groups, as illustrated below.

"...Em, maybe mental health issues [are not covered in depth]. Alcohol and drugs misuse. Because she's working in quite a vulnerable caseload, she has addressed that herself...

Well, I do have concerns, if she was maybe in another practice, for the simple reason that she would be looking at the child, and maybe not have the background knowledge of the mental health issues." (Mentor 8)

Another mentor reported some concern that the breadth of the programme actually constrained in depth study.

"...[The programme is] pretty much what we were expecting, but I think it's trying to cover an awful lot, which means, I think at times, she feels she's skimming the surface an awful lot, and not getting into any depth. Whether that will be improved on next year....?" (Mentor 6)

One of the sponsors suggested the learning outcomes for the programme and information for programme participants could be further refined, as follows:

"....Either that the learning outcomes are more structured so that they are easier – rather than have a big wordy outcome that contains a lot of things within it – more 'SMART' related and also perhaps a more realistic word count or else more preparation as to what exactly is to be included to gain your marks and also I think more in depth at the beginning of the programme to do with referencing because that didn't seem to be very clear. Obviously my referencing system for the masters programme appeared very different from the information that [Name of Programme Participant] was given but when she was marked on it, it turned out they actually wanted it the way I had done it and that wasn't explained in any of the information that [Name of Programme Participant] had." (Sponsor 4)

The programme design was well-received by mentors and they particularly liked the balance between university, distance and work based learning.

"I think [Distance Learning] it's a good thing. I did my health visitor training in a very similar way, in distance learning and then having a couple of residential parts to it, and I felt it was invaluable. Even the things that you're going and picking up from the two days of residential bit, you're doing on a day-to-day basis, but just going in and networking with your peers, and people doing the course in other areas, I think it's invaluable. And I think it's a good balance just having the two days, every now and again." (Mentor 7)

5.4.9 Views on the Capability Framework

The domains within the Capability Framework (NES, 2009c) all seemed appropriate to the students' role in practice as illustrated below.

"...I think that [the five domains of the capability framework] they're all tackled. I think that they've gone through each one of those domains as being covered by the university. And I think that they're getting, in their practical situation, that these topics are all part of the role, and that

they're being covered. Probably, it's just like anything else, sometimes one comes up time and time again, and then it falls away for a while, and then another area is looked at." (Mentor 11)

Some mentors reported that the learning outcomes and the items or competencies within the Capability Framework could be difficult to apply and time consuming to translate to the local practice settings. As the Capability Framework and items/competencies tended to be presented as relatively high order categories mentors were interpreting and applying these to their setting which could make it difficult to ensure mentors' assessments of practice were consistent. The mentor below refers to time spent considering how the learning outcomes applied to their particular practice setting and that eventually after reading through the documentation the focus became clearer.

"... [the domains and competencies], usually [became more obvious] after a bit of reading, but I wouldn't say, it's one of those things you don't look at it and say, right that's what we've got to do. You have to sit down and spend some time reading the whole thing, which sometimes, although we work together every day, you're trying to do it within the working day as well and sometimes you just want something that's dead obvious, that this is what we want to achieve at the end of this, so that you're not actually spending so much time working out where you're going," (Mentor 9).

The domains and competencies were appropriate to all aspects of another participant's role as highlighted by the mentor below.

"...[They are good]..I think as we went through them (domains and competencies) in our mid-term interview, it was clear that the path that we had identified for [Participant] while she was based here, she was going to meet those domains, and she's easily fulfilling the competencies. She's literally breezing through them, well I think she is. I think the competencies are relevant, I think they address all the different areas she is seeing in her day-to-day work here, and in [Place] I would say, I think it's all relevant to what she's doing. In fact, the domains are what we used to identify what her role would be initially, so we looked through that first to see what she would need to achieve, and then set her role accordingly." (Mentor 7)

A mentor for a participant with a previous background in education was finding the programme content very relevant for the student's new healthcare role.

"...Yes, it's really relevant. Because [Programme Participant] came from an educational background, it's all kind of new, looking at it from a difficult angle, health and wellbeing angle. But what's quite good is that [Participant] works alongside me the days that I'm working, so we work closely together, so every case, we discuss, and she can link it up.

And do you think the programme is building on the participant's experience? Because it sounds as though she has come from quite a different background?

Yes, it certainly is building on it [building on the student's experience]". (Mentor 8)

When one of the participants in an acute setting was asked to comment on their confidence and competence in the domains she reported she had developed specific new skills.

"...Well within the plaster room we do special casts – like [type of cast] – casts that you don't do every day in a plaster room and I've been doing them and I'm definitely getting better at them. So I'm developing skills in them which I'm really enjoying...we've been doing different dressings. If you have a patient coming into resusc – basic like assisting the doctors in resusc – that's really interesting." (Participant 14)

Another participant thought her practice had developed in the areas of child health, wellbeing, nutritional and oral health. However this participant was responsible for the care of a child in the child's home with limited opportunities for partnership working.

"...I'm a bit more confident about certain things within the practice like the child's health and wellbeing. More into their nutrition and oral health...We're always on our own ...I always go back to oral health because that's a big part - and I have looked more into that." (Participant 15)

The nature of the local practice area meant that in some placements participants had less opportunity to extensively apply their learning about ethnicity/ multiculturalism.

"...Most of the stuff that we've talked about so far has been very familiar, both to me and to them. And it's part of the job, both of them undertake regular training in aspects of child protection and mandatory training that we have to do for the job anyway. So a lot of it is stuff that would have been covered in that mandatory training and in part of the nursery nurse training. I think it's formalised it, but I'm not sure how much extra it's added to it at this point in time. But it's very early days, and we've got another six months, so I suspect actually that what comes up later might be of more relevance than the first thing, which was very much more introductory. And learning stuff about ethnicity, multicultural stuff, we have a very, very small number of multicultural cases, within [local area], and that's just because of our demographic makeup. But while it was useful to them, but I don't know how relevant it was to the jobs they are doing. I think if it had been in [city], then that would be different, because our demographic in [local area], that hasn't had much impact on the way they work...: The things that they are doing on the Rights of the Child at the moment will be different, as they get through the workload for that and the reading, that might be different.." (Mentor 4)

Depending on their practice setting participants expressed a need for more in depth preparation in areas such as child protection as in the case below where a participant stated that this knowledge could enable her to better assist the qualified nurse.

"...my mentor and my coordinator of the group have been very good at trying to get everything into place, and I would say that the main thing was this family liaison course, and the child protection. So I would say that they're both on the horizon, the things that I really wanted to do. And I've been in viewing the school for Additional Support needs, I was in last week, viewing how the children that are there, and the activities that go on there, so that's been interesting as well. Though personally, I think I'm

more for mainstream because that's where my experience lies, in mainstream primary." (Participant 13)

5.5 Accessing academic support during placement

When one participant encountered computing problems she felt able to contact the lecturer at the HEI. *"I got in touch with them to let them know that – I did find it difficult to get some of the e books and that – in fact I found it easier just buying stuff – I bought quite a bit of materials from Amazon."* (Participant 12). Similarly another participant approached the lecturers when she had problems accessing Moodle.

"...Yes I've contacted them [HEI lecturers] a couple of times – just for very simple things. A couple of weeks ago, I contacted them about not being able to get onto the campus Moodle and things like that. Previously, I think I had contacted them once or twice asking if they had received email (because I'm so rubbish at it) – asking for feedback on things that I had sent them. Apart from that, not really." (Participant 14)

Participants were also able to access lecturers via the Tuesday *Chatline*, and in some cases they arranged for a collective group of participants and mentors in one NHS Board to meet with the lecturer.

"...The tutor has arranged for a Tuesday evening where [refers to Lecturer] is on line as well and we can chat with [Lecturer]. I would just say at the minute people are building up relationships there, rather than any actual work. There's just odd things come up that you learn as you chat, as you do when you're building up relationships....We have two tutors attached to the course, and they've been very helpful. Lecturer A has been out to visit us. [Lecturer] came last Monday, we arranged a visit from her and she met with the five students in [NHS Board], and all our mentors. That was really helpful for everybody concerned." (Participant 3)

In one isolated instance, the lecturer was not able to respond immediately to a programme participant's request for assistance. *"I know [Lecturer]'s very busy but [Lecturer] doesn't always get back to you."* (Participant 2). However, this was not a general view, as evidenced below.

"Yes – we've got teachers - they are easily contactable. You can email them or telephone them....Yes that works really well. They respond to you very quickly. Sometimes you can even just pick up the phone and you can catch them in the office. They are definitely back to you within 24 hours – I've never had to wait for a reply back from them. They are never far away for advice." (Participant 6)

One participant, who for practical reasons could not take part in the Tuesday *Chatline* sessions, had alternative arrangements in place for contacting the lecturers.

"I've submitted a couple of the essays and have had constructive feedback from the two separate tutors who marked it, one was [Lecturer A] and the other was [Lecturer B], and I'm on the right track with what they are saying. And we have an online chat, though I can never access it because it's on a Tuesday because that's the busiest day of the week with the kids here, that [Lecturer A] comes on every Tuesday at a certain time

and actually has given me a personal mobile number because I'm dyslexic but not essay based – I can manage all of that, but sometimes structuring everything together, putting things in sequence – that's where my problem occurs, so [Lecturer]'s offered that, I can only say that [Lecturer A] has been very supportive...as far as I am aware, the first time [Lecturer A] met my mentor was when [Lecturer] came up to meet all the mentors and all the work team together. People who were having difficulties and things, and [Lecturer] would iron them out.” (Participant 9)

From a sponsor's perspective, the routes to academic support were very clear. If a student was having problems with academic areas they would be directed to the HEI lecturers.

“Yes, that's what we've tried to make quite clear, that it has to be the academic tutor, and they go online with regards to that, and use the chatrooms, if they're having problems with their academic work. But I think that time will tell how they've got on with it, because it has been a very different style of learning for them, being on line, and most of them have gone through the challenges of being online.” (Sponsor 1)

Similarly another sponsor considered academic support unproblematic.

“...They do mention that they have tutors there, and also they have mentors here in [NHS Board] who have been identified to support them. They do know how to contact, and summon support. I don't think there's any problem there....[the placement didn't have contact with the HEI before the start of the programme] No, not before the programme. But what happened, it kind of all happened at the same time. We have actually had a visit from [HEI], they came and met with the mentors, they came to our area, and that was great.” (Sponsor 3)

5.5.1 Academic level of programme

There was general acceptance that the academic level of the programme was appropriate, and that the majority of participants were able to meet the programme requirements. When asked about a student's experiences of studying at SCQF levels 7 & 8 the following mentor stated *“No, no it hasn't been a problem studying at those levels”* and that the student was definitely coping (Mentor 10).

A participant observed that academic expectations were high.

“... It is a lot – it's a HNC and an HND within a year and it was only May that we started – it's a lot in a year...this is the first time I have gone into studying since the school and I was like – I don't even know what a diploma means. But we get to graduate.” (Participant 11)

Even though some participants had studied recently they had not been required to develop academic writing skills or complete essays on these courses and so the academic demands of the current programme seemed greater.

“ I did a [clinical] course two years ago, an [specific clinical] course, and that was quite intense but it was more a practical thing – there wasn't any essay writing or anything like that – it was really just reading stuff and

learning things that way. That was hard but there wasn't any essay writing – that's the first essay writing I've done since my SAQ in 2000. And how easy or difficult has it been for you to work at the academic level? Nightmare! It's getting better now. At the beginning I honestly didn't have a clue – how to plan an essay and things – I didn't have a clue.” (Participant 14)

According to one mentor some who did not have academic credentials struggled initially and had particular difficulties sourcing material online and using the library.

“...but when you haven't come from that [academic] background, and the first thing you're doing along those lines, a lot of the problems is the academic stuff, they don't know how to write an essay, they don't know how to reference material, they don't know where to look for stuff. And maybe something before they started, along those lines...[Programme participant] felt that what she got in [HEI] wasn't very much, and when she went up, she didn't have much of those skills before she went, and it's through all of us in the department helping her with that part of it, not just me. Because that is where she's had the most difficulty, she's not been used to resourcing the material on line, getting books out of the library – things like that.” (Mentor 9)

In contrast a mentor reports that another participant without a formal academic background appeared to have adjusted well to academic study.

“I think she's very very keen to do well. She hasn't got an academic background that I'm aware of. And the transition has been very good for her. I think she's quite an able person. She's maybe not had the background, sitting courses and doing things in the class, but this could probably lead her into further education.” (Mentor 11)

Others with limited academic experience appeared to successfully make the transition to studying in higher education

“... I think I'm getting to grips with it – I don't think it's beyond my capacity. It was a bit strange to me at first because I worked in [work location] for [many] years. I never did anything academic apart from the other things I've told you but I think it's manageable.” (Participant 12)

The mentor below clearly identified that the participant had good opportunities to apply her learning to practice and was coping well with the academic and practical demands of the programme.

“ I think [Participant]'s easily achieving what she needs to, what has been set out for her to achieve. As I said before, she's a very clever, very well organised practitioner here with us, so I don't think it's below her, I think it's stuff that she's learning on a daily basis as she comes into contact with all the diverse families that we work with. I think it's set at a good level, she can relate what she's learning to what she's seeing on a day-to-day basis.” (Mentor 7)

5.5.2 Residential study blocks

Participants were expected to attend the residential study blocks and their employers were asked to fund their travel and accommodation expenses. Sponsors of participants in the Health & Wellbeing in Schools Demonstration sites were able to meet these costs from their budgets, *"Yes it's been costed in."* (Sponsor 5), but for some of the other sites these expenses were problematic. For participants located in remote areas, meeting the significant travel costs was difficult as according to the manager below this had not been included in their budget.

"Obviously funding is always an issue and we haven't been able to get funding from the training budget for the second two days that [Participant] had to attend which meant that it had to come out of the school nursing budget and there wasn't actually money there so we overspent....and I think when I first applied for the course, I was told that it was funded by NES but I didn't realise that travel and accommodation wasn't funded so coming from the [location]..". (Sponsor 4)

Nonetheless, the residential days provided an important opportunity for participants to meet each other, their lecturers, and to be introduced to the university systems including e-learning.

"Yes, they're definitely beneficial. It's great to meet up and get the peer support from the rest of the girls who are doing it. It's great to meet up with the tutors – they have been great. I found it very beneficial having the residential days – definitely....What was actually really useful was when they go through the system with you – in the first two residential days we went through the whole Moodle system and the library system and then when we were back up there in September, they went a wee bit further into it, the library system, accessing articles and all the different databases. It was really useful." (Participant 10)

Another participant was very positive about the value of the residential block in minimising any sense of isolation on the programme, but reported that some of the time could have been used more productively.

"Oh [the residential study block was] absolutely invaluable – just to get that moral support from your fellow students. Oh so it wasn't just me who was feeling like that or it's just nice to meet up with everybody and we've all just got on really well so it does make a good support network for each other and I think if we didn't have that meeting up, you would feel really isolated." (Participant 11)

One participant suggested that a 'mock module' on Moodle would have been very helpful and that more time could be devoted to accessing and using Moodle.

"...I know a couple of my colleagues felt that because we hadn't done anything like this before, it would have been really helpful if we had been given a "mock module" if you know what had I mean and had been told like this is what you are going to get, this how you get on to it, and what to do with it – basically just tell us how to get started off." (Participant 14)

Participants commented that the second residential study block was more useful than the first block.

"Well I felt that one was more structured. We got feedback on our first year on our results and I was told that I had passed and that was really good because at least then I felt like I was heading in the right direction, because up until then I'd felt pretty unsure about it all. Also they had shown us what module we were doing and what I'd said to you earlier about getting a mock module – well they showed us the module and said this is what you will be going into so it was more structured, it was definitely better. We spent more time with the IT person, just going over different things like going into the library and things like that so it was definitely much better." (Participant 14)

Participant 13 also commented that the second block was more structured than the first.

"Yes it [2nd residential block] was fine. I enjoyed it much more than the first time – the first time I felt we didn't get a lot out of it – and I think all the girls were the same. Some of us speak on line on a Tuesday night – but I know when we went up for the first visit we came away feeling, oh goodness me, we didn't know where to start – we very much felt like that – we would maybe at that part liked to have found out about the referencing and what kind of structure they wanted the essays to take, but we came away not knowing much, but the other one was much better, especially the second day, because we had an insight into palliative care which was very interesting, and a lady came along from the looked after and accommodated children, and that's also going to be part of this module and luckily for me, I've been out with a nurse prior to that so it was very interesting and that was more of what we were looking for. I would say the first day, the morning – there wasn't as much to it as could have been – the afternoon was going over the clinical documents and things. I would say the Tuesday morning, not a lot happened, and the afternoon, we were discussing the clinical documents and things. And certainly the Wednesday of the January visit was very good." (Participant 13)

Participant 15 thought the second residential block gave an opportunity to catch up with others. As they were all undertaking a new course she commented *"Yes - we feel a bit like guinea pigs - but you just don't know what it entails. It's like when you write the essays you just don't know what they are looking for."* Another participant highlighted the need for guidance and practice on using e-learning to be included within the initial residential block.

"...I certainly think that there needs to be more time on the practicalities of using Moodle. But in saying that, when I left I thought oh my goodness I have no idea what I am doing but once I started going into Moodle it became clear and they did say that – the mentors did say that it would become clear when you start using it and they were absolutely right. On the two days you need reassurance and you need more actual work... Everybody was just saying - you couldn't really concentrate on what was happening because we just wanted to see the module and I think that if that had been done first – as it was getting later on and on the second day, we were thinking oh my goodness we still haven't been on this Moodle to see what we were doing. The mentors did their programme well

but it could have been better organised. Well we did a lot of access in the library and I think that was important.” (Participant 2)

Although the residential block had been challenging, the librarian’s session was extremely helpful to many students.

“I found it [Residential Study Block] completely overwhelming and daunting, and I’ll have to be honest and say that in the two days that I was there, the person I found most helpful and most beneficial was the librarian. She was amazing – what she didn’t know - because I think that everybody just took it that we all knew what we were doing computer wise – we all knew everything – whereas we didn’t, but she just laid it out in simplistic terms and was fab. In fact we all thanked her because she was amazing – she was brilliant.” (Participant 9)

The general impression was that content could have been condensed and more targeted.

“...There were bits of it really useful, and bit of it maybe weren’t so We travelled down early in the morning, we were able to travel and get there for 9, we left here at 6.30. And then we had an overnight stay, I mean, it was a good experience, and it was good to be at the university and meet...Well obviously the information about the course, that, and getting all the bits and pieces of paperwork [was useful]. The library thing was really good, how to access e-books, because probably to the majority of us that was new. There was a little bit ... in that we did in the actual nursing school bit with one of the tutors, and we watched a DVD... a scenario, about how a doctor spoke to people, and that was quite good. Then there was a bit in the actual ward bit, with the dummy, and the respiratory thing. Don’t get me wrong, it was good, but I wondered if we could maybe have missed that bit out, and done it all in one day or something, instead of having to stay overnight, some people had to stay two nights. I’m not saying it wasn’t relevant, but I don’t know how important it was that we all did that. We all had to do the basic life support in my workplace anyway. That sounds like I’m being really ungrateful, but it’s just an observation that maybe if it could have just been about the course, the actual content, how we were going to do this distance learning – maybe it could have been condensed a bit.” (Participant 4)

A further participant indicated that time could have been used more effectively and could have included activity based sessions.

“I feel that there was only, out of the whole two days, there were only two hours that were actually quite relevant. One part was the woman from the library showing us how to use the library and the library online, and the other was them showing how to get on the computers and everything to begin with....I feel they could have given us, there were like a couple of bits that were really good, I felt they could have given us longer on them. Like, the library woman was there for a morning, she was really good, and she had loads of different exercises for you to go on and find books, and pages, and just to make sure you could use it. And I felt like we waited the whole two days for [the lecturer] to give us an example, it took [the lecturer] two days to show us the front page of the course on computer, and that was the only day we got to see all five

parts of the module. And once it came onto our computer, we only got Learning Outcome One came up on our computer, first. And we wanted to see an example of an essay, and we wanted to see examples of how to do referencing, and she only had ¾ of an hour on the second afternoon for that.” (Participant 5)

5.5.3 Programme delivery methods

- **Perceived advantages and disadvantages of e-learning**

The blended curriculum comprised designated residential study blocks, e-learning via *Moodle*, access to a *Chatline*, and work based learning.

A participant explains the centrality of e-learning to the programme.

“On Moodle we’ve got our learning outcomes, and through those outcomes we’ll have a number of activities related to the subject that we are studying, so we evidence all that - we save them on our pc and print them out, whatever way we prefer doing it, and we have the evidence that goes with that.

Are you finding it relevant to the work that you do?

Absolutely, definitely. You can see everything fitting into place through the course work and I can definitely apply it to my job – definitely....I’ve got no faults at all with the university side of it and the support is great. Everything is really clear because I did worry about the distance learning and I thought how is that going to work but I must admit all the facilities are there for you and it’s all clear and easy to understand. The support is definitely there. I think it’s actually an ideal way of learning because you are just left to get on with it – yes you have the pressure of your deadline date, but you can basically work round it yourself as long as you’ve got your final deadline and everything is done by then. Definitely good.”

(Participant 10)

For participants in remote locations the *Moodle* system offered distinct advantages.

“I think it’s really good, when we’re in quite a remote geographical area, it enables someone to have a fulltime paid job, and yet gain qualifications. So I’m quite in favour of it...The support is there if we need it, and the paperwork is very self-explanatory, and I think it’s a lovely way of working.” (Mentor 6)

At the beginning of the programme IT support was problematic for some. The participant below describes her frustrations when she failed to find quick answers,

“...to the sort of wee questions that if you had someone there and then, you could just nip in and ask them.” She concludes her problems with distance learning are because of her previous experience “ ...when I went to college, it was for four days a week, and there was somebody standing there, flesh and blood, that I could speak to. And it’s maybe just a hang-up I’ve got about it being distance learning. It may come...”, (Participant 5)

One participant contrasted her school learning with recent study and commented that instead of attending lectures she was now learning through

doing activities *"...it's quite different, distance learning, from getting a lecture. And that's where I think the activities come into their own. Instead of getting a lecture, you're learning through the activities, obviously."* (Participant 13)

- **Computer literacy**

One of the sponsors highlighted the need for programme participants to have academic and IT skills to support their learning and that these should be built in to the actual programme.

"...I don't think it's so much regards learning material, but I think there has to be acknowledgement that not every student is going to be coming on the course with brilliant IT skills, and also the ability on how to reference, and how to do literature searches and things. And while I think it was potentially offered at the beginning of the course, I think both felt that they were OK, they'd be able to do that, but actually it might have been better if that had been a compulsory part of the course, and they would be able to take that forward a bit more, because I know one of them had found it quite difficult to look at the right literature, and know how to reference things as well." (Sponsor 2)

Some of the participants highlighted their unfamiliarity with computers.

"I've found that the distance learning thing has been a struggle, maybe because I am not very computer literate. I did find that's been a bit of a struggle to begin with and then at the beginning of second year we all got booted off the computer – I think that there were problems with the computers, so I never had access [to MOODLE] for about two weeks...Access to Moodle, for about two weeks but that all got sorted out and we got an extension and things. I don't know if it was an IT problem, so it's wee things like that that was a bit of a struggle...As I say, the computer part of it is the biggest problem because I'm not computer literate and anything that I have to do through the computer can be a bit of a struggle but I am getting the hang of it now." (Participant 14)

Another student attempted to write notes during the residential block sessions to help her with accessing the computer when she returned home.

"Well it's really all new to me and I've kind of struggled with it because I'm not brilliant on the computer. We don't use computers at work – it's all written by hand and delivered and collected by hand – the confidentiality thing. Using the computer, I've had to learn that as I've gone along and that's made it really hard...they were telling us how to get into the e library and things like that but I just wrote it all down because I'd never even heard of anything like that before – I was just writing it down stage by stage so that I could come home and practice it. I couldn't physically do it there and I knew I wouldn't remember it – I'm not confident with computers. So I did it that way – I'm getting there, but it's slower." (Participant 12)

- **Accessing a computer**

Those programme participants who didn't have access to a home computer sought access elsewhere.

"If you don't have access [to a computer], I think people have helped [participant] out, and she has been able to get it, but it's not been as straightforward as just going home, and to get access to a computer – she's maybe been going to friends with computers to access some of the material." (Mentor 9)

And in some cases lack of computer facilities resulted in failure to access some of the recommended resources.

"Well actually, me personally, because I don't have the internet at home, that poses a bit of a problem, only because a lot of the references and links are from YouTube and things like that and so my work doesn't allow me access, the library computers don't allow me access, so you know there are a few things that I feel I've been missed out just through not being able to access them." (Participant 1)

When initial computing problems hampered some programme participants at the start of the programme one participant supported colleagues by downloading and forwarding programme documents.

"When we first started, I was almost like a mini IT department because I seemed to have no problem getting into things but the other girls were having problems so I was forwarding on the documents that I was able to open. I think these issues have been resolved but certainly for myself, I've not had any problems accessing the links or using the e libraries as well, I think a few people were having problems with that but I wouldn't have been able to do my assessments without that – I think they are great." (Participant 11)

Many of the participants were located in shared offices and accessing computer time could be difficult as illustrated by one participant, *"...my only problem is that the office that I'm in, there are three nurses and me and there's only three desks and computer, so it's like musical chairs."* (Participant 13)

One of the sponsors was aware of one participant's IT access problems that could be related to the age of her home computer. *"Again, one of the students has been having quite a lot of difficulty. She's been able to access it, but unable to open it, and I think that has maybe been the oldness of her computer...."* (Sponsor 2)

- **Group working and using *chatline***

Participants were encouraged to work with peers either in person or virtually through the online resources. When asked if the participant contacted other students to share ideas about learning tasks the mentor below gave the following affirmation.

"Yes, it's part of the project, nurse healthcare assistants, there are four of them, they're also doing the course. They get time, I don't think they get any formal study time, but they can certainly arrange to meet up informally every week if they chose to." (Mentor 6)

However, the small group size in cohort one limited opportunities for group discussions.

"...but there is only three of us doing Stage 1 – there was four but one had to give it up. So it is quite a lonely course. There isn't a lot of people to be able to talk to but that is just the way it is. Obviously the other people are having to do it from Stage 2 and I wouldn't change it but it would be nice to be able to have more people to bounce ideas of....but as I say it's quite difficult because there's only three and maybe I'll only have [participant] on one night or because the other people cannot come on...you can access the chat at any time, and I find myself on Moodle quite a lot but, and there's nobody on it. If there was more of you, I would imagine that every time you went on it, there would be someone else there to chat to, to say, how are you getting on. But most of the time I'm on, I'm on my own. And I'm sure the others feel the same."

(Participant 2)

One participant was unable to join the *Chatline* discussions due to prior commitments on the set day.

"I'm struggling a little bit I suppose with distance learning, because going into a classroom you are a little bit more disciplined and you have to be more disciplined within the home setting if you are going to continue doing the studies and submitting it online and being completely computer phobic it is a bit of a nightmare – but no it's fine – I am motivated and I actually quite like the course content, so that helps....I just never get to access a computer on a Tuesday because [other commitments]. And it's a shame, that's one thing that's a downfall. I think it should be like a rolling programme because I can never make a Tuesday night, ever. I think maybe one week it shouldn't be a Tuesday, maybe the following week a different day – I think it's too set in stone. I've never discussed it with her but I'm sure they would change it." (Participant 9)

A sponsor acknowledged the value of group support locally where five participants were able to support each other.

"I think it's working fine. Because there are five of them, they're actually linking in with each other, and getting quite a bit of support from each other for things. But I think if you were doing this on your own in isolation, it might be more challenging. But I do know they're contacting each other, and supporting each other with certain things, so that's been quite positive. I think because they're a mature group, not in their age so much, though there is that element, but the fact that they came into this with their eyes open, they knew what they were doing, so I think that's made a big difference." (Sponsor 3)

Participants had varying opinions about how useful the *Chatline* resource was to them.

"To begin with there was three of us [on the Chatline] on the course in the second year. At first, because we didn't know each other, it was changed to everybody, but I'd don't think it was put to full use – they spoke a lot of rubbish really. I think this time round, because we spoke about it when we were up there – we're going to use it in a more positive way towards the course. We've all agreed to do that." (Participant 12)

Another participant however enjoyed the social aspect of *Chatline*.

"On a Tuesday night, there's online chat. There are usually just three of us ever on. Now and again, there's an odd one or two come on. But when we met up again at [HEI], it was very good, because we felt we knew one another better, and it was quite good socially as well. Not that we went out or anything, but on the day, there was quite a bit of banter that went on, so that was good. But [another Participant] works in the Additional Support School in [Place], and her and I go up to [HEI] together, so we can bounce things off one another. I'm finding the Tuesday night chat quite good, if there's something you're not sure about, it's quite good to bounce off the other girls." (Participant 13)

Unfortunately some programme participants had difficulty accessing *Chatline*.

"...sometimes there's quite a few problems in terms of getting access. Entering the chat rooms and things like that – I've had a lot of difficulty with that and I think it is really important to be able to access the chat to see how others are doing and be able to speak to my tutor and the last three weeks I've had huge problems with it and not been able to get it." (Participant 2)

One of the programme participants expressed frustration with using *Chatline* and accessing e-learning material. Communication with the lecturer through *Chatline* proved unsupportive for this particular participant because she was unable to sustain a dialogue to solve problems when other students with urgent problems took priority.

"...I don't think [distance learning] is working for me at all...And sometimes when we're on the live chat on a Tuesday night, the lecturer is doing another couple of other live chats at the same time. So I could go in and ask her a question at half past 7, but maybe not get an answer back until 20 past 8, or 8 o'clock, depending. And if somebody has got a big problem on one of the other live chats, she'll say em," leaving you now, going to somebody in trouble in another live chat room". And she goes away and speaks to them. And sometimes you're not any further forward....It's just, this long distance learning, it's actually making me think I might not last the two years at the course." (Participant 5)

Participants could access further reading via the links on *Moodle*.

"You can actually go in, with the references and everything that they give you, you can manage to do your essays and everything with it. But there are always further links, so if there's something particularly takes your fancy, you can actually read more into a topic, or more into one topic than another, if it's more relevant to what you're doing at the time." (Participant 5)

- **Programme materials**

The majority of programme material was delivered to participants through e-learning, with some additional input during the residential study blocks. Participants reported very positive experiences of programme content but accessing electronic sources was time consuming.

"The material on the course is very enjoyable – it's not a chore to go and actually read over the things because everything is quite interesting, it's

new to me and I am enjoying it....Yes, well certainly there's a lot of reading and maybe it takes me longer because just I am new to it – it does take quite a bit of time to do it - but I am enjoying the material very much and the way it's broken down. Yes, I think it's taking shape, it seems quite good.” (Participant 3)

The next participant echoes the above points.

“I think the content of the course is really good – I really do like it but I find it difficult to get into the e library and look up something. I actually think that more materials should be readily available and that sounds lazy but it's not – it's just awfully time consuming, especially if you are working full time. You are working full time, you are working shifts and you have your own chores at home to do then you have to try and spend a lot of time trying to access materials – I do find that difficult.” (Participant 12)

If participants did not have a home computer some would access work computers but NHS computer firewalls restricted access to some sites. The mentor below refers to difficulties experienced by one participant in another NHS Board to access *Moodle* because the participant did not have a home computer.

“...I think the initial few weeks there seemed to be a problem [accessing Moodle], and also some of the course work they were getting, because of the firewalls that are in place in the computers in [NHS Board], they weren't able to access some of the links, because there was YouTube footage in them, and that has been blocked in all the workplace computers. And [Participant] doesn't actually have access to a computer outside work.” (Mentor 9)

Some participants stated a preference to work from text books rather than electronic books. One participant had bought personal copies of text books rather than use these or library copies.

“...I've ordered a bit of materials from Amazon....For the first part of the course, it was £72.

A significant amount of money.

Yes but the course cost of lot of money so for what I am learning, I am quite happy to do it.” (Participant 12)

Participant 13 also preferred to access hard copies rather than online books.

“...I would say that I'm not wild about the on-line books if I'm being perfectly honest – I like a paper copy but that might just be me because when I do an essay, I tend to be flicking through everything, and looking at it as I'm typing it up. I don't write it out first, I type it straight on – this is my preferred way of doing things like that. I'm not wild about the online books, but that's just me...I've been very lucky because I've been able to go to one of the hospital libraries in [Place] and they have been very good at giving me books. I must admit this first essay that I'm doing this time, most of the stuff is on line – I haven't been able to get any books at the moment.” (Participant 13)

Mentors were also positive about the programme structure, content and lay out of learning materials. *"Yes, I think they [course materials] are well structured."* (Mentor 8)

The 'pink booklet' for recording participants' performance in practice was the document that mentors accessed most.

"...I haven't done anything on the academic side. I've discussed how they've gone around doing their practice assignments, looking at the evidence for fulfilling the different aspects of the course, the feedback sheet that you have to fill out, we've gone through that in quite a lot of detail, and discussed what aspects of their job fulfil that, and what extra information they've needed to be able to succeed in those particular criteria...It's the pink booklet, yes. It was actually very easy for us to do, because the things that were in it are the things that [Programme participants x2] are expected to do as part of their job anyway. So I was fairly sure that was going to be straightforward for them anyway, because it was part of their training that they undertook to do the job, and their qualifications as nursery nurses." (Mentor 4)

Another mentor stated that the programme documentation was comprehensive and well aligned to the participant's work role.

"...I've been through all the paper work with the student. So I know it's about children's health and public health, and looking at communities, looking at the effects on families, physical and a varied course. And I felt that the student was in a very good position, working with the HV team, because she was ideally placed, particularly to meet all the demands, everything that she was to achieve, for the needs of the particular course...it's wide enough to let them see all the different effects that families can have, and vulnerable situations that they can suddenly become involved in, but they can get go into things in more depth, as well... they seem to be looking at things in quite a lot of detail, they're not skimming over things. It seems to be a good course for the student, and I can see the difference in the practical application and the confidence in the student, just through working alongside her. I can see a difference, in her understanding of family dynamics and situations." (Mentor 11)

Mentors would have liked access to Moodle and thought it would be useful to be able to read the programme material from home as they were too busy to do this at work; some reported spending time trying to do gain access.

"...I think because I'm busy with workload, I tried to access it [Moodle] from home, and just from laptops, and our laptops, I don't know whether they're a wee bit out of date, and my husband was trying to help me, because I'm not the best on the computer, and he is quite good, but we couldn't unscramble things...My student uses it no bother. And she says that – I think if I had time at work, she could show me a few things. But I don't have the time at work." (Mentor 11)

Mentor 7 thought it would have been useful to be able to access the material on Moodle during the early part of the programme to advise the student.

"We did actually speak at the beginning whether we thought it might be a good idea for us, as mentors, to be able to access the materials, certainly when they were getting their heads round what the modules were and the

objectives and things. It might have been quite useful. But then it's an ongoing thing as to whether we would need that or not, really. But I think [Participant] is managing that perfectly." (Mentor 7)

Others had explored gaining access to the HEI website with the lecturer from the HEI.

"We did speak about that at the meeting with the tutor, actually, but we don't have access to the [HEI] website to get onto some of the materials. But [Participant] is very good in sharing with me.

And is [HEI] keen to make that [a password and access] available to you in the future?

Not that I'm aware of." (Mentor 3)

5.5.4 Practice and university based assessments

Mentors recognised that it could be difficult to maintain objectivity in assessments if the student was known to them.

"...What I think would be difficult for me, would be if I had a student who was a stranger to me, and I didn't know their capabilities, whereas I knew this student. The only thing I'd say is maybe you're not, you know, objective enough, because you know the student very very well, because they actually work with you and are a member of your team. So it's different from when you've got a student nurse." (Mentor 11)

Where practice based learning experiences didn't match the learning outcomes a participant struggled to meet the assessment requirements.

"...Well the first part of it was better than the second part [programme]. I think the second part has been a bit more stressful because time is running out and we've not been well supported as far as getting placements because our [Community Support Worker] role doesn't cover the age range that we are looking at through the course and on top of that I'm still not even going to be getting any training until January for the [community based] role so I'm not even out there with any mothers or families and I'm finding it really frustrating and it's really demotivated me so I think my course has suffered. My motivation is lagging a little bit now because I feeling I'm being let down and other areas....A placement with a health visitor would have been ideal but nothing happened and we just had to keep on saying we need placement... I just can't see how I am going to be able to sign off my clinical document and it's really disheartening because I've worked so hard on the theory side of it and it's just the actual practical side that it has been through a lack of support and organisation at this end – it's nothing to do with the Uni – you know – it's at this end that I feel I have been let down – it's not been seen as important – the support has not been there that was promised." (Participant 11)

In another case the participant was engaged in administrative support tasks rather than the practical experience she had anticipated and indeed required to be able to meet the practice requirements. She suggests that the HEI might pick up that she is not getting the practice experience required.

"...The role that we took on of support worker, I thought that we were going to go in and do innovative work within the schools with a lot of pupil contact, but at the moment it's turning out to be a lot of admin based support for the school nursing team. But that's the thing we're trying to iron out just now....We've got to do all the practical, which is a little pink booklet which you must be aware of? I haven't actually had a chance to sit down and go through that with my mentor which we should have done but it has to be taken back when we go back to Uni in February so that will be interesting to see how that links up. At the moment I think it will be ok because a lot of it is to do with communication which I am having to do, but it may be more sticky later on. I'm hoping that's where the gaps are going to show. People will think, hold on a minute, you're not getting an awful lot of hands on experience. I've got a few family contacts, because that's what I used to do but at the moment I can't see how it's all going to work out." (Participant 9)

One of the sponsors in a community setting referred to the challenges she encountered to ensure that participants had suitable practice experiences to be able to meet their learning outcomes. She had not anticipated the participants would require extensive placement experiences outwith their work role.

"...I thought I had nothing better to do than to employ them and put them on the course but when we looked at their learning outcomes just by working in our area they weren't going to meet all those learning outcomes so we had to obviously get them other supervised placements so that was a wee bit trickybut nothing that can't be resolved ...do you know what I mean because its such a broad course it would be difficult for any one area to meet those requirements so I don't know if other people have come back about that - we needed another NHS and local authority placements to make sure they were covered .. .that provides a better learning experience for the students. One of them still felt she should have had a broader placement but its hard when you are trying to run [a service]." (Sponsor 6)

Many mentors were experienced in mentoring student nurses but without this background further information would have been required around *"...the assessment procedure, the placement assessment. If I didn't have any of that [student nurse assessment] experience, that would be something I would probably need help with."* (Mentor 3)

In reference to the written assignments participants found the assignment word limits restrictive.

"...The only comment that I would have that's a bit negative is that at the end of each section we do a learning outcome, which for the first three are formative and we send them off and we get feedback on them and the amount of words is fairly limited. Something like 200 for the first two that I did, and then 300 for the next one so you're very limited but I guess that may be a complaint that all might have - I don't know....The last one that I did, I think I was four hours trying to cut it down to something near the 10% - I didn't quite make it - it's very tight but that may be a common complaint from all students - it's certainly challenging." (Participant 3)

One of the sponsors also picked up on the restricted word limits for assignments.

"...but what I would stress is that I don't think the assessment process is very good for example there doesn't seem to be a huge word count for the assignments that they undertake and this last one she's done, there are two questions within the one learning outcome and you are only allowed 400 for the whole assignment. Trying to condense 200 words into each part is almost impossible and it almost becomes useless information because it doesn't actually say anything..." (Sponsor 4)

The format required for the presentation of assignments was also commented upon by this sponsor.

"...And it's just you know, every establishment is different and every tutor is different as well – how they like things laid out and presented and I don't think there was enough of that [presentation of work] given to that at the start of the course." (Sponsor 4)

Participants described their satisfaction when they received assignment feedback.

"...Yes, the theory side of it is great – I'm doing really well and I'm dead chuffed with the feedback that I get back and at the end of the first module, I got an 'A' so it really gives you that sort of boost and after each assessment is submitted, we get feedback and it's marked on a grid and it's how you put your content together, your presentation, your referencing and all of these sort of factors get individual grades and I'm mostly As and Bs so when that comes back it's like – yeah – I'm on the right track." (Participant 11)

5.5.5 Protected study time

Access to study time was considered important by some mentors. Within the placement agreement between the HEI and placement there was an expectation that students would have a study day per week (pro-rata). There was variation in the study time participants reported, ranging from those who were granted the agreed time, through to those who had none.

"...I think the issue of working to college dates is pretty good, and she's certainly needing one day a week off to do her studying. I think that would be a comment for maybe any future people, is that they've got to have that one day a week off." (Mentor 6)

Participants recognised the value of protected study time in addition to the work they undertook in their own time.

"...Yes we're very lucky – I just work 5 hours a day and I get 5 hours a week. I work 20 hours but I do get 5 hours. I honestly don't know how I would have managed without it – it's been really good...I'm definitely putting more hours into it than the hours I am getting from the study leave. I think it just depends how much you want to get out of it yourself. I like to think that I'm quite keen and I want to do the best that I can, and get the best marks that I can." (Participant 13)

In this case the allocation of study time was monitored by the lecturer.

"And then it was quite good from our point of view because we have got protected study time, so the tutor was checking that we were getting study time. I am and I'm not having any problem with that. We get three hours study time a week." (Participant 4)

Another participant was also granted study time.

"...[I have] 5 hours a week study time and I can take that time and go home and still access the coursework online...5 hours is not enough to do all of it but I do get a good part of it done in that time.[I need] Probably about another 5 or 6 hours on top of that maybe. I tend to do most of the work in the evening in my own time so it's maybe 2 or 3 hours a couple of times a week as well as study time." (Participant 7)

In contrast some participants did not appear to have protected study time in place, as illustrated by the participant below.

"... the only thing I struggle with is the time management because I am currently not getting any protected time through my work to do it. ...The allocated protected time was in the agreement that was signed off by management, but it has never ever come to play. It was something that I did question initially – you know, are we going to get this, because I actually only work 20 hours in this post. So I was keen to even up my hours for to get even..... obviously.... I think they said it would be a day a week allocated protected learning time, obviously that would be pro rata, so it would have worked out about 4 hours a week for me but it's not come to place but to be honest,..." (Participant 10)

A participant who did not get study time stated that she did the academic work when she was on night duty or on days off. *"...We've got to do it at nights or on our days off sort of thing." (Participant 15)* Another stated, *"No, I do it [study] all from home I don't have time at work to do it – I do it all from home." (Participant 2).* Similarly, participant 11 noted that *"I certainly haven't been given time."*

One of the sponsors referred to a plan to protect study time, but these arrangements were not yet in place.

"...That is something we're working on just now [protected study time], I'm actually working on a paper for the head of nursing to identify. It was discussed when we nominated them and put them forward, that they would need that, and that they would need protected time. What we actually didn't do was put in the process anything round about this is the protected time they'll get. A lot of them are doing stuff in their own time, which is what we'd expect anyway, for anyone who is doing an academic programme, but what we're trying to build in is some time within their practice area that they can concentrate on their portfolio development, and also doing the online activity. So therefore what we're thinking about is that when it comes to their academic assignments, that maybe that's the bit that they should be doing in their own time, because all the online activity builds up to academic assessments." (Sponsor 1)

In other situations participants benefitted from allocated study leave, although this sponsor thought they may need more time.

"But we're giving all of them half a day a week study leave. That's equating to between 3-4 hours, and I wouldn't be surprised if they're doing as much again themselves. You're looking at probably up to 7-8 hours/week they're doing on this. That's a considerable amount, and without the support of paid study leave, they'd be struggling. (Sponsor 3)

The situation was mirrored with that reported by another sponsor where all students locally had protected study time each week.

"...I think they get a study day a week, and they've found that very useful to have, and that's taken some of the strain off, like working and having to study at night. They use the discussion boards at night. And I think they've found it quite manageable." (Sponsor 5)

5.5.6 Perceived impact of programme on performance

- **Personal and professional development**

Mentors and participants were able to identify and consider a number of positive developments in participants' performance. These often related to growth in the participant's self-confidence, and contributed to advancing the self-development of the practitioner, as noted by the mentor below

"...I think she's getting a lot more confident and a lot more assertive with the things she's doing. Her communication skills are second to none, and have been since day one, but certainly going out to schools on her own, and organising the P1 screening and the immunisation events, I think she's a lot more confident. And with the theory that she's learning, I think she's getting a lot more confident in different things that she's learning and the things that she's seeing. Certainly with the vulnerable families, you know, the child protection families that she's got some input into... She's certainly coming to us less and less with queries, and I think she's filling in a lot of her own knowledge gaps...I have no worries - if she continues to work as part of this team, I think she'll continue to go from strength to strength. In fact, if she did stay in this role, I've got a feeling that she'll probably be looking for more. If she any opportunity to stay in this role, I can see her going on to doing something further...I think she's got a wealth of experience she can share with us, and the other way round." (Mentor 7)

- **Role development**

There was also some recognition that the programme had given participants an opportunity to consolidate their work-based learning and academic development. General comments illustrated that participants were addressing gaps in their knowledge, consolidating experience and gaining confidence, as illustrated below:

"Yes, definitely, she's developed, and it's given us a framework to where should we be developing her, and where the gaps are. It's a good framework. One of her gaps was that she hadn't worked with child protection and vulnerable children within a class education. And also in sex education, she hadn't done any of that kind of work. It wouldn't have dawned on us, had it not been for the paper work. So she went out with

the school nurses to make sure she covered that...She's competent [in those areas] now. It's just the case that she had never been part of it before. Yes, not knowing how to even introduce the topics in some ways. [And in reference to the impact of the programme on the participant, she stated] I think it's consolidated the knowledge that she already had, and it's giving her the confidence that she knows all these things, these aspects. But for her, in particular, it was a consolidation of previous work." (Mentor 6)

When participants were asked about their progress in the domains identified in the Capability Framework responses were generally positive. It appeared that they may be gaining a better understanding of 'why things are done', and the theory underpinning practice, rather than developing new practical competencies.

"...I feel OK but I do think that my confidence has grown. I'm the type of person if I am unsure about something I will ask and I will seek advice and do some reading...I think I would be a wee bit more competent because I've got a better understanding of why things are done – before I did them because I was trained to do them but I didn't know why they were being done – I have a deeper understanding....I feel it's given me more confidence and I feel that if somebody approached me and asked me something I think I would be able to give them a more in depth answer." (Participant 12)

A mentor suggested that the programme had empowered the participant to progress to other roles in the future. *"I have no worries - if she continues to work as part of this team, I think she'll continue to go from strength to strength. In fact, if she did stay in this role, I've got a feeling that she'll probably be looking for more. If she any opportunity to stay in this role, I can see her going on to doing something further."* (Mentor 7)

The increased depth of understanding was emphasised by a particular participant. *"...So I would say yes, it's definitely helping me with the job, and giving me a much closer and better understanding."* (Participant 13) and an increased ability to apply theory to practice was noted by the mentor below.

"...She's a very knowledgeable woman anyway. She's done some health and wellbeing training in the past, so she's really keen to get to grips with these things. I think as the course is progressing, she's been able to put theory into practice a lot more. And yes, I do see her role developing, in that she'll be able to have a more hands-on approach with the families that we're working with. Still in a supportive role, but she'll be able to be a lot more involved." (Mentor 7)

The background of the student may have influenced their perception of how useful the programme was as illustrated by the participant below who had moved in to health from an education role.

"I think I've got a better understanding, because I didn't come from a health background, I came from an education background. So I think I've got a better understanding of the health background, and how things are done, which was new to me up until last March. ...I would say I look at things differently.... We did Speech and Language as one of the modules as well, and I work with the SLT quite closely, I

would say that that was good input for me, to go in a wee bit deeper to what they're doing. And I was able to bring my experience of working with [SLT] into that part for the essay. So I would say yes, it's definitely helping me with the job, and giving me a much closer and better understanding." (Participant 13)

Increased confidence and extension of role were considered to be consequences of undertaking the programme. *"I think that I'm becoming a bit more confident in what I'm doing. I suppose in a sense being given a bit more responsibility to do things so I'm enjoying that."* (Participant 14). In contrast to the majority, one participant highlighted the limitations of undertaking the programme when practice opportunities were restricted, as in the case where practice was focused on the care of one child.

"[The limitations] - it's just mostly just having the one child. I think someone else doing the course, you need more than one child, definitely...I think it would have been a lot more variety [if she cared for more than one child] - to see the differences ...if you had other kids you could look into more things in more depth with certain things - and play as well..." (Participant 15)

Participants were stimulating discussions in the workplace as a result of undertaking the programme.

"I've enjoyed the discussion a lot of it has generated, we've discovered quite a number of interesting things, and [Name of Programme Participant] has found out facts that have brought discussion to the department, of has made us rethink some of the things we do, or some of the things we take for granted, or assume about people." (Mentor 9)

One sponsor perceived that participants were already working at a high level and so the areas for development were likely to include psychomotor skills but particularly management and decision making, and another considered that a participant was already making changes in practice.

"... I think the five that we have got probably already work at a fairly high level for support workers. We had a strategy in place for our support workers from 2003, so the five that we have got are actually already very skilled support workers. And although some of them will be developing some more psychomotor skills, most of them will be going into it as more round about more detail on the management and decision making within their role." (Sponsor 1)

"...I think certainly for one of the students in particular, I think she has already been able to make changes in her practice, one of the students is in the fortunate capacity of working in another position, as well as ventilator carer. She works as a community nursery nurse as a Band 4 in a GP practice in [Place name]. So she has probably found it much easier to apply some of the theoretical training and information that she has received on the course... she's going to come and speak about something at the next carers' meeting, so I think it's going to benefit the whole team." (Sponsor 2)

Another sponsor located in a Health and Wellbeing in Schools Project demonstration site reports that participants are helping to deliver 'better' support for children who need it but that this is difficult to quantify.

"...I think what we are doing is making sure that the children that are more vulnerable are getting better supported. I don't know if we're necessarily reaching more children, but we're reaching children in a better way...Certainly, we have had very positive feedback about the course, although also the feedback is that there is a lot of work involved in it. And I do think that these particular individuals are working very hard in developing this new role, within a combination of existing structures. And I think it has been very challenging for them on many fronts. But certainly the training has given them a focus and something to anchor onto, but whether we've seen a difference, I really don't know I can say one way or the other." (Sponsor 3)

In contrast, a sponsor was unsure whether a demonstrable change in participants' practice was yet apparent due to their early stage in the programme, but this sponsor had previously noted that these participants were already working above the level expected of a support worker.

"At the moment it's early days to say how the content of the programme, to date, has actually changed what they're doing, although there are some small bits of anecdotal evidence for it. I was round last week speaking to one of them, and she was saying how she used the cultural component of the module of what she was doing very much in her practice in that particular week, and how she'd helped other staff in her ward with regard to some cultural needs of some children. And developing her understanding of how you actually deal with this particular family. So I think it will start to come through, but I think it's maybe a bit early yet to see that." (Sponsor 1)

The confidence some participants were gaining allowed them to be more independent in their roles.

"...To see how much she's progressed already is really rewarding to see. it's as if she's an advocate there for families, they see her as non-threatening, it's as if she's on their side, and the relationship she's got [with families] is really really good. And she's been working across agencies, CAHMS, SLT, and school nursing. And you can just see, from shadowing, and then someone overseeing her doing basic health and screening things, she's now out working on her own. She's been allocated her own tasks without supervision. But they both very clearly know their boundaries, and when they need to ask for help. Their reporting systems are really good. I get them to fill me in, once a month they send me an update sheet on what they've done, where they are, and how they're progressing, and you can see it from the first month to now, their personal growth is just huge." (Sponsor 5)

Further evidence of increased independence was also noted.

"...I think their keenness to get their own caseloads now, and they're asking, they're feeling they're ready. [Name of Programme Participant] in special needs has her own group of pupils that she's working with, and developing new ways of working and ideas of health promotion, and [Name of Programme Participant] she's working in lower education,

children in Primaries 1, 2 and 3, she's got puppets in. The span of how they want to deliver their classes is huge." (Sponsor 5)

Additional confirmation that the programme was fostering increased confidence and independence is provided by the mentor below.

"...Well, I think the communication and working with different agencies, that is really good in this role as well, because I think this course has given [Name of Participant] the confidence to phone social work, to discuss it with the school nurse, with the different agencies working within the family..." (Mentor 8)

The above participant also described her improved understanding of the school nurse role, and how she now contributed to the school nursing service by relieving the school nurse of some routine duties.

"...Before, when I worked with the school nurse, and if you'd asked me what she did, and I've admitted this to them – I would have said she comes into the school, and she takes their height and weight, she talks to them about different things, and that's it. I basically thought that's all she did. Now working with her, I know she does an awful lot more than that! I think it's a great idea that the likes of myself can take a lot of the workload from [Name of School Nurse] I've asked if I can take a puppet in, so I go into the schools and I take a puppet with me, when I'm working with the lower primary, especially when it's head to toe hygiene, and I make a wee story up that the puppet hasn't been very clean, hasn't been washing his hair and stuff, and they love it – they love it. And through that, it takes away the focus on me." (Participant 13)

One sponsor noted the participants' development from management and strategic position.

"I am specifically looking at this from a NHS perspective, early years perspective, that we have got these posts that we can use the broader remit ...they have got a great understanding of child development, on inequalities in health, health promotion planning, and evaluation ..." (Sponsor 6)

5.5.7 The future workforce and participants' career plans

This theme encompasses organisational perspectives on the future of SHCSW and AP roles and participants' personal career aspirations.

- **Organisational perspectives on the future of SHCSW and AP roles**

There was general recognition of the need for senior health care support workers and assistant practitioners to be included in the future healthcare workforce. Whilst some mentors had concerns about introducing another level of staff they were positive about the abilities of individuals with whom they had worked. There was also recognition that individuals who didn't have health care experience could take on these roles with appropriate preparation. However concerns were raised about overloading the participant with delegated tasks or indeed not using them to their full potential.

"As I said, on both ends of the scales, I would have concerns. But as I

said, [Name of Participant] has a lot of common sense, so that helps! And I think when the course is finished, they will be very, very valuable members of the team. And we are a team, we are involved with HVs, nursery nurses, HVAs, school nurses, and myself... My fear would be that people expect them to do more than they are qualified to do – that would be a fear. And also, on the other end of the scale, that staff would be frightened to push them to do things that they will be qualified to do. But we're talking about people from a non-clinical background to do a job in health. And sometimes for nurses it's difficult to think right, ok, they can actually do that even though they don't have a nursing background. This course – I'll tell you, is a really difficult course, and they're doing well, having had no clinical experience, being able to get through it... I suppose it's hard to say, because it's a new role. It's not a role that's been going on that can feed in and make a difference to something that's already existing...It's actually been a big role for not a lot of money, to be honest. And the health support workers are really expected to take on a huge capacity of work. But we will definitely see the impact of it. It's going to allow school nurses to do what they're actually paid to do...." (Mentor 3)

Support workers in the demonstrations sites faced an uncertain future, but their mentors hoped that they would continue to have posts at the end of the project.

"... I think things will pan out. I hope in 2011 we'll be in a position where the HCSWs will stay in post. ...I don't know what the outcome will be of it all, to be honest. I'm just thankful that I've got [Name of Programme Participant] because it's fine, it's really good, and we work well together, and it's really good for our team." (Mentor 3)

In some cases there was a perception that greater preparation of the wider team was required.

"..Because my worry as an ex-HV as well is, these girls are potentially being trained and would be very, very valuable to a HV team, but to my knowledge, there hasn't been any discussion with HVs out there to see if they would be accepting of another skill mix within their team. There have already been issues about staff nurses within HV teams, nursery nurses, now we're looking at yet another qualification working with HV teams. While I could see where the course and the background information and everything they were looking at developing would fit in really well there, I wasn't sure how well that would actually go down with HVs." (Mentor 2)

From a participant's perspective, there may be tensions within teams related to the scope of the new roles.

"Well it was kind of plugged as in the end of the second year – we would be qualified at assistant health practitioner level but there is no such job, certainly within [NHS Board] so there is kind of a feeling on one half that this is something that is going to be brought in, kind of like a health visitor assistant and on the other side they say that's like taking away skills because we don't have a nursing background to move into that direction, people are saying that we're coming in the back door and taking away the nice jobs. So there's a lot of issues with other health professionals about the role." (Participant 11)

Financial constraints may limit the numbers of people appointed to healthcare support worker roles and could restrict the numbers of qualified staff providing supervision. The mentor in the following account suspects that they will not have sufficient finances to be able to appoint staff to SHCSW and AP roles upon completion of their programme, or to ensure sufficient numbers of suitably qualified professionals to supervise their work.

"My fear is financial constraints, that we won't be allowed to recruit, the way things are going. In an ideal world, I think there's a great role for them, because they have an understanding of what we're doing, and can go out to do visits on a more general work, as well as giving the more specialist, advisory work. So I think there's a great need for them, if we can convince HR and politicians that they are needed... I think my concern would be that they would cut back on enough qualified staff to adequately supervise, especially in a remote geographical location. You could end up with people covering quite skilled work with very little supervision, and I think that would be dangerous..." (Mentor 6).

"...the worry for us is I suppose is that we've got [Participant], and she's learning all these valuable things, and she's taken on all these different support roles, and the worry for us is that that's going to stop... I really think there is a future here, for the simple reason with health visitors now, we are dealing with a lot more vulnerable families, and we haven't actually got the time to do what [Participant] doing with the families... we go out there and assess the families, and I've got one family that [Participant] works very closely with, and she's out twice a week, helping support mum, and just doing basic things with mum, teaching her how to play with her child, basically. And that's twice a week, and I wouldn't have the capacity to do that twice a week." (Mentor 7)

There were some concerns that participants in generic therapy support roles may not be able to progress beyond their current role.

"I think they're going to get stuck [because they are not in defined therapy assistant roles], because they're not going to be registered as any one therapist, and they've not got state registration, so I think career progression is going to be a problem....I think some schools would welcome them with open arms, and other schools would still think it had to be a qualified therapist who came in to 'do' the therapy. Whereas we can see that if the therapist can set a programme, then a support worker is quite able to go in and do the work." (Mentor 6)

A sponsor was unsure how employers would assimilate the different bands into their organisation's workforce.

"...And I'm wondering how this course would enhance people's opportunity, when applying for posts, that they would be picked out, or that had done this qualification. And ... what's the difference between a Band 3 and a 4, because when you get to a Band 5, you're at a qualified level. Are we trying to identify an alternative qualified status, but at this level? That's what I'm saying." (Sponsor 3)

Others highlighted the uncertain financial future.

".. I'm hoping that we'll be able to keep them, but with finances being very tight, I'm not sure how that's going to happen. But I'm hoping, we're

doing a review of Community Nursing within NHS [Name of NHS Board] just now, so I'm really hoping there will be some opportunity to keep these two, but we can't guarantee that, which I find very hard." (Sponsor 5)

" My fear is financial constraints, that we won't be allowed to recruit, the way things are going. In an ideal world, I think there's a great role for them, because they have an understanding of what we're doing, and can go out to do visits on a more general work, as well as giving the more specialist, advisory work. So I think there's a great need for them, if we can convince HR and politicians that they are needed... I think my concern would be that they would cut back on enough qualified staff to adequately supervise, especially in a remote geographical location. You could end up with people covering quite skilled work with very little supervision, and I think that would be dangerous..." (Mentor 6)

Despite these uncertainties, generally sponsors were optimistic that senior healthcare support worker and assistant practitioner roles would form part of the healthcare team in the future.

"Well I think it's very exciting, because using things like skill mix, and an opportunity to investigate what the uniqueness of each post is, and not just saying, replace same with same, but saying actually, who is the right person to deliver certain pieces of core work. I think the development of this role is quite pivotal to the future of the NHS, actually. Because we haven't looked into this enough in the past about how we can have a support platform underneath our qualified members of staff. To say actually, these are roles that can be very well carried out by people with appropriate training to do some of the routine core work, and leaving qualified professionals to do some of the more complicated, targeted stuff that they are better qualified to do. But the NHS is not in a great place financially, but it would be realistic to be looking at developing the HSW role, as a way of building sustainability into services." (Sponsor 3)

A sponsor in acute care referred to definite plans to increase Band 4 posts within the organisation and so completion of the programme would contribute to this objective.

"...I think certainly the plan is, on this site in [Place Name] is that these five staff will go into Band 4 posts, so it will take them up an additional band within the Agenda for Change salary scale. And that is already being looked at just now, because that was the overall aim of supporting the five staff into it. And the member of staff who is working within the long-term ventilation service, they're actually looked at the overall profile of that service, and the roles in it. And they're looking specifically at what the Band 4 will do as opposed to the Band 3. And they're doing that within each of the services that the staff are coming from." (Sponsor 1)

- **Participants' personal career aspirations**

Participants understood that successful completion of the programme did not automatically mean they would be promoted in to a Band 4 post and some believed that nurse training was the next logical career step for them, as illustrated below:

"I think the next step would be to go and do your nurse training to be honest.

OK that's what you're feeling is it?

Yes, because we're all band 3.

OK. So you are all band 3 and do you envisage that there will be band 4 positions?

Well I don't know. The role I do out with my night role at weekends might be doing band 4 which I did a niche thing in - I did a dressing clinic and they might up us to 4s."(Participant 15)

Due to uncertainty surrounding their future job some were considering options for further education in disciplines such as nursing and social work.

"... Our concern just now is - we're doing all this work just now and what are we going to have at the end of it, apart from our qualification. Obviously this is the pilot for it, and it has come from the Government, and I don't know whether there's a possibility that there will be roles available for us as assistant practitioners, because I don't actually see that role coming up very often in vacancies - you know - an assistant practitioner...I would like to think that there will be something at the end of it. I have had thoughts of moving on and doing some more studying but I am not committing myself to that just now - I'll see how this year goes. I don't know whether they would look at knocking something off the nursing course and things like that. There have been different rumours about things like that. I'll just concentrate on this just now and see at the end of it. But it certainly makes me think I can do different things - I'm capable of doing it." (Participant 10)

Another participant was undecided about her future but had a positive attitude to remaining in post.

"I haven't a clue to be honest. At times I think I should go and do my nurse training but I don't know - I think I'm getting too old for that...sometimes you think that you are just happy in the way that you are and it's just doing something different." (Participant 15) Whereas in other cases completing the programme had empowered some to consider further professional development. *"...I don't know if I could maybe do a degree in social work or something like that. This is a new qualification, a new pilot so I couldn't really tell you but I'm sure it will [lead to something else]."* (Participant 2)

The uncertainty about future roles was particularly acute for participants on fixed term contracts in the Health & Wellbeing project demonstration sites.

"...The post is 18 months which will take us to the end of March 2011 and that is also going to be evaluated and there is a very definite hope that there will be funding there to keep us in post. There are four school health support workers in post through this project." (Participant 3)

"...I'm not 100% sure about this, but my understanding would be if the project is going to be rolled out, and that they are going to retain this amount of staff after March 2011 - it wouldn't be guaranteed that you'd get the job - you would have to apply for the job I think." (Participant 4)

An additional concern for the Health & Wellbeing in Schools Project participants was that *"The actual contract for the job will finish before the course is due to finish but I think that there are arrangements in place that we will be able to complete the course even if the job doesn't continue."* (Participant 3)

"...Doing the course? It's just a qualification that we are going to gain within the role, but the project is actually – this is where it is going to turn quite tricky – the project is only for 18 months which finishes in March 2011, but obviously the university course ends in June. So there's a little bit up in the air, who will fund the remaining part, but hopefully because we will have started the second part of the second year by January/February we should be able to roll forward with it." (Participant 9)

5.5.8 Overall evaluation of programme: experiences and suggestions for future programmes

A range of positive experiences were reported in a general way by participants such as *"... I think the programme's very good"* (Participant 13) and that it was a very good preparation for working with families. The extent to which the programme met the learning needs and expectations of participants is illustrated below.

"...It's meeting the needs of what I want to learn and is going to help me get down the career path that I want to go and working with families is excellent; the broad spectrum. There's a lot of work involved without a doubt – a lot of reading – but it's a very good course I've got to say for giving you the knowledge and the experience for working with families." (Participant 6)

Another participant was very satisfied with the programme design and content.

"I'm finding it fairly straightforward. The information online is very good and very straightforward – really it's just down to time management and trying to fit everything in. But the actual course and reading is very good." (Participant 7)

So how is the learning helping – is it supporting you in the role already or is it something that you will be useful later?

"I would say both. It's important for my job role now and I think it will definitely help in the future." (Participant 8)

Some programme participants were aware that the impact of their roles would be evaluated.

"...I do think the course as it stands, it is really worthwhile and I keep saying that to the other girls on the course. I think it really helps them out and I can see them making a headway through it, and relating things to their own personal work experiences and work cases and families, so that's certainly what you need to be doing...It's a two year course – or two years that we have got funding for, so it will be up to us to show that it is working and that it is making a difference and the stats will reflect that." (Participant 1)

As already presented within the mentorship theme, generally mentors were very positive about the impact of the programme on role development of participants.

"...it has been very good for the student that I've been allocated. It's built up her confidence, and it's let her see really what the role is...I would say I find it positive, yes... it's wide enough to let them see all the different effects that families can have, and vulnerable situations that they can suddenly become involved in, but they can get go into things in more depth, as well... They seem to be looking at things in quite a lot of detail; they're not skimming over things. It seems to be a good course for the students, and I can see the difference in the practical application and the confidence in the student, just through working alongside her. I can see a difference, in her understanding of family dynamics and situations."

(Mentor 11)

One of the sponsors was very complimentary in comments about the programme.

"...Well, basically we're quite happy with it. The mentors don't have any concerns about it either. The tutor has been down, they've all met, and the communication and links are good. I don't have any concerns about it at all." (Sponsor 5)

- **Suggestions**

Less positive evaluations related to organisational aspects of the programme such as accessibility of materials within the introductory two day residential block, the length of the initial block, preparation of mentors and the restricted scope of some practitioners' practice placements. The majority of these elements can be attributed to this being a new programme and to the speed with which it was developed and launched, but the latter two aspects merit careful consideration for future programmes.

"....When we were there [reference to residential course at HEI] the modules weren't actually put on Moodle and I would say if we were going again, then the modules need to be up before we go so we can actually look and say this is what we need to do whereas we were going on to Moodle and there was nothing on it." (Participant 2)

"...I think it [the introductory two day residential block] could have been condensed into at least one day and that would have been very helpful....it could definitely have been condensed and the organisation could just have been a bit slicker."

(Participant 3)

"...Maybe it [residential block] could have been done in one day, or maybe they could maybe have not had to stay over for two nights, for the people who had to travel further than we did. It might be something to look at...."

(Participant 4)

More specifically, one of the residential blocks one of the problems identified by participants related to the inclusion of cohort 1 and 2 students' combined attendance in the same classroom.

"...[the lecturer] was trying to tell each individual group at what stage they were, but we were all in the same room. It's sheer nosiness, but you can't help listening to what other people are getting told! Everybody was told where they were to start, but you could take the option and right back to the beginning and start from scratch, like if you had been given a later place to start on the course. So she spent about half an hour with these people to try to decide whether they wanted to start half way through, or whether they wanted to go to the beginning and start from scratch. Whereas if we'd all been taken into single rooms, then you would just have been focusing on what you were going to do." (Participant 5)

Preparation of mentors was patchy for the first cohort but seemed to be perceived more positively for the second cohort. In view of the large responsibilities placed on mentors relating to programme content within the work based learning mode of delivery, the preparation of mentors is therefore crucial.

A further limitation highlighted by certain participants to be overcome for future intakes was the variation in placement experiences during the programme.

"...The only thing I would say is the placements – if they are not all getting the chance to go on placements. I think it would be nice to have that written up that the employer would have to grant you the equivalent of one day a week and it wouldn't have to be study time – it could be learning on the job. It would be nice to have some placement put into that as well – say 10 days or something." (Participant 6)

Section 6: Discussion of findings from the evaluation

6.0 This section discusses the evaluation findings in relation to the overall aims of the evaluation.

Aim 1: Evaluate the outcomes of the education programme in relation to the five key domains of practice

In phase two of the evaluation (descriptive survey using postal questionnaires) participants mainly reported 'confidence', or 'some development needed' in theme one, knowledge for practice; they reported similar self ratings for theme two, partnership working; for theme three practising ethically, and for some aspects of theme four, care and intervention. Within theme 4, however, participants reported reduced levels of perceived confidence in some aspects of the assessment of holistic health needs of CYP particularly in caring for looked after children, children at risk of abuse, mental health and wellbeing, sexual health, in promoting of age appropriate relationships. In theme five participants rated lower perceived levels of confidence in input to local guidelines, audit and training and support of others. The lack of confidence in these areas could be partly attributed to their degree of experience.

The six participants who returned a second postal questionnaire reported higher levels of confidence across each of the statements within the competence framework, suggesting that they had gained in experience from both the programme learning, and practice in placement. The data reported in phase two focuses mainly on participants experiences of the early stage of the programme with the majority of questionnaires being returned during the first part of the programme in semester one.

A number of reports within phase three (qualitative interview study with participants, mentors and sponsors) also address the first aim of the evaluation. The Capability Framework and the five key domains of practice were generally considered appropriate for programmes at level 7 (SHCSWs) and level 8 (APs) although the wording in the Assistant Practitioners' *Clinical Assessment Profile* Capability 4.1 (domain four, care and intervention) suggests that the practitioner should be assessing CYPs and family needs, rather than *contributing* to this assessment. The Capability Framework generally appeared to give participants the opportunity to develop their knowledge, understanding and skills relevant to their roles, to identify gaps in knowledge, and was generally perceived to be a good framework by mentors and sponsors. From the participants' perspective the CF enabled them to gain a better understanding of '*why things are done*', i.e. the rationale for interventions, rather than gaining new practical competencies. Some mentors commented favourably on the discussions taking place in the workplace as a result of the topics being studied by participants on the programme. The scope of the SHCSW and AP roles are referred to in the programme content and capabilities but there remains the potential for students to hold misconceptions about the boundaries and scope of their roles. They do not hold a 'case load' but are working under the supervision of a registered professional; occasionally this point did not come across clearly in participants' comments within phase three. The scope of roles is highlighted

in the Royal College of Nursing's *Guide for registered nurses and support workers* (RCN 2006) which identifies that the supervision, accountability and delegation of activities is key to providing safe and effective care.

A few mentors reported difficulty in applying capabilities within their setting due to the need to translate them for the local context. They referred to having to read the documentation carefully and to spending time thinking about how students could demonstrate achievement of the capabilities. The full *Clinical Assessment Profile* (CAP) (RGU 2009) detailed examples of evidence that could be accessed to support students' practice capabilities but these were not included in the final *Student and Mentor CAP* documentation. Ready access to examples of sources could be helpful to both participants and mentors. It is also possible that different mentors could have diverging opinions on what constituted evidence of achievement of the capabilities which may have implications for the consistency of mentors' assessments of students. Some lacked clarity about the mentorship role and in the early stages of the programme many advised on students' academic work, as well as practice related issues, although others were clear that their role was to focus on providing support and advice in placement and to assess the participants' practice capabilities. A further point relates to the potential for identifying core and specialist capabilities within the Clinical Assessment Profile as these could go some way to addressing the diverse practice locations in which students were located.

The wide range of settings in acute, public health, community and schools meant that the programme was seeking to develop SHCSWs and APs in a range of roles located in specific or specialist settings and in more generic public health roles. Within the phase three data there was evidence that many were developing their capabilities but it was also apparent that some participants (either in the early stages of the programme, or in particular settings such as home ventilation support) experienced difficulties accessing practical experiences to meet practice capabilities and learning outcomes. This may have resulted in some inequity of experience. For some participants, therefore, the restricted nature of their roles presented challenges for meeting practice capabilities and learning outcomes. The completion of the *Placement Agreement Contract* (RGU 2009a Detailed Programme Descriptor) for the education programme was designed to ensure that students had access to appropriate placement experiences but in some settings this was difficult to achieve due to the narrow focus of some roles or because there was limited scope to take up placement opportunities.

Within the original programme planning document (RGU 2009a) mentors were viewed as crucial to students' support in practice. Their preparation was vital given their responsibilities to encourage the development of students' knowledge and understanding of theory and/or evidence underpinning practice through the *Clinical Assessment Profile*, and the assessment of their practice capabilities across the five domains. Mentors appeared to rely on participants providing mentorship and programme information particularly through the distribution of a *Student and Mentor Handbook* (RGU 2009c). Direct contact between the HEI and mentors could only take place after the mentors had been allocated. There may be scope to improve the communication of mentors' contact details from placement to the HEI and to

record these data centrally as this information appeared incomplete during the early stages of the evaluation.

The majority of participants reported positive experiences of mentorship and often cited mentors' previous experience of mentoring nurses as advantageous. Mentors often had limited prior knowledge of the programme so the overall positive experience of participants suggests they had taken steps to equip themselves for the mentorship role. The intention of the HEI programme team had been to invite mentors to attend preparation for mentorship sessions at the HEI but in many cases this had not been feasible, or the invitation had not reached mentors.

In the majority of cases the mentor already had working knowledge of the participant. This familiarity could potentially have made it difficult for mentors to remain objective in their assessments of participants' practice capabilities. The mentors had sole responsibility for recording the participant's practice as '*satisfactory*' or '*not yet satisfactory*' within the practice placements. Even where participants were not originally known to mentors, it is possible that mentors might feel compromised in failing them, due to the continuing professional relationship with the participant, although we saw no evidence that this was a problem.

Most participants considered the education programme to be very worthwhile. The blended learning curriculum was helping them to gain capabilities for the SHCSW/AP role in CYPH as well as an academic qualification. Particular strengths were the breadth of programme content, the high quality of online learning resources including live *Chatlines*, and the formative assessment process that enabled students to develop their academic skills and achieve a 100% pass rate (as reported by the HEI education providers). Some mentors thought the breadth of content covered limited opportunities to explore and analyse topics in depth. However participants' previous experience of studying within higher education or other personal characteristics may also have been important factors in determining students' ability to analyse issues in depth.

Aim 2: Evaluate the appropriateness of the education programme for the SHCSW & AP roles

It should be noted that the overall trend in the evaluation data suggests that as participants progressed in the programme they tended to become more aware and appreciative of the personal and professional value of their education and this was reflected in the later interview data in phase three.

- **Academic characteristics of programme**

Within phase two a minority of participants held higher education academic qualifications (not specifically related to children and young people's health) at Master's, Bachelor and Diploma level. A further group held qualifications relating specifically to children and young people which included HND, HNC, Professional Development Awards and Nursery Nurse Examination qualifications in Childcare. Further participants held qualifications at HNC

level in Social Care, Supporting Learning Needs and others held SVQs in Care. Qualifications dated back to the 1970s in one instance, and as recently as 2009 in two other cases. Just under half of the participants reported having undertaken academic study within the last five years indicating an academically diverse group that could have major implications for students' academic performance.

How participants in phase three of the evaluation perceived the academic level of the programme was influenced by their previous backgrounds and academic experiences. As illustrated above and supported by phase three data, participants had a wide range of academic backgrounds and some had not studied recently. Even so the majority of participants appeared to be coping well with the academic demands of the programme and made positive comments about programme delivery methods, mentorship, programme content and the learning materials provided.

The admission criteria for entry to the education programme followed the HEI's standard entry requirements for students entering Higher Education with the additional specification that students were employed in CYPH. Through the accreditation of prior learning process some participants with a CYPH qualification at level 7 were eligible to enter study at level 8.

According to the Detailed Programme Descriptor (RGU 2009a), students were to be offered a pre-programme self-completion *learning needs assessment* by the programme team in order to assess the students' prior learning experiences and ascertain access to online learning and computer skills. It is not possible to establish from the evaluation data if this process was carried out for every student and as already noted the experience of one student who did not have a computer (either at home or at work) suggests that it was not. Within the programme's blended learning approach module delivery on campus hours amounted to 15 hours per module, whereas online activities accounted for 175 hours and private study 90 hours (for 30 credit module). Hence an exploration of students' access to computers in different settings was clearly required particularly due to the reliance on computers for delivering a programme to a geographically dispersed student group. It is possible that students may have under or over rated their IT abilities due to a lack of familiarity with the standard of computer literacy required.

- The assessment strategy:

The eight 30 credit modules leading to the award of a diploma included four theory and four practice modules. Theory modules were assessed by completion of learning outcomes within a portfolio, written assignments and satisfactory achievement of the capabilities in the work-based learning modules.

As reported by the education delivery team, to date all students had been successful in their academic and work-based learning assessments at the first attempt. Whilst this is to be commended, interestingly it does not reflect the normal distribution of marks commonly seen in Higher Education assignments, and may be attributed perhaps to the development of students' existing knowledge of the client group or the selection process (which may

have identified highly motivated students). On examining the assessment processes used, lecturers' provided formative student feedback on a substantial proportion of the written assignments; this strategy could be expected to impact positively on students' academic performance.

The written assignments comprising small units of 200 to 500 words could potentially limit the opportunities for students to demonstrate the SCQF level 7 criteria. SCQF level 8 criteria commonly include critical debate, analysis, development of academic argument but the evaluation team were unable to access evidence about the level 8 assignment to confirm or refute the attainment of level 8 criteria. If the programme is rolled out to other HEIs this assessment strategy may require diversification to achieve parity of assessment and word counts with other programmes at these academic levels (for example other HEIs may use examinations and/or discursive essays.)

Protected study time was a requirement of the programme and where this was granted participants definitely benefitted. However participants reported variability in access to protected study time and for some, all of their programme work was being completed in their own personal time. Inequalities relating to protected study time should be addressed for future students, as they may reflect a tension between the demands of service delivery and educational development.

- Residential study blocks:

Programme/educational orientation, further curricular content and direct contact with lecturers was offered during the two day residential study blocks. The self-development of students can be observed through their evaluations of the first residential study block in comparison to the second one. The first 'block' was focused around delivering programme information and academic support and was clearly valued by participants for the opportunity it afforded them to meet with other students and 'network' with them. Peer support was valued because it allowed participants to share experiences and reduced a sense of isolation. In spite of attested proficiency in computer usage, some participants clearly would have welcomed more guidance in the use of *Campus Moodle*. Need for support with referencing and essay writing was also identified. The contribution of the Librarian during the initial study block was particularly valued by many participants, which suggests that face to face support for students facing unfamiliar academic processes is an important consideration when delivering distance learning programmes, and is recognised by the HEI in the programme documentation.

During the second residential block, students were able to receive academic feedback on assignment work, which allowed them to self monitor their progress. Participants' reports suggest that the structure of this study block had improved on the first and that it met their learning needs more directly. This may well have reflected a growth in their academic self-confidence. The personal learning and development gained during the residential study blocks clearly outweighed the practical difficulties encountered by those participants that included the distance from the HEI, and interim childcare arrangements.

- **Appropriateness of the education programme for SHCSW and AP roles**

The programme documentation reported in phase one of the evaluation indicated that during curriculum planning the programme had been mapped to the SCQF levels 7 and 8 criteria, and to the NES Capability Framework for SHCSWs and APs (NES 2009); the latter in turn having been mapped to the NHS Knowledge and Skills Framework. In view of these processes the programme had the potential to meet or exceed the requirements for SHCSW and AP roles in children and young people's health.

In phase one of this evaluation it was noted that through the e-learning environment of *Campus Moodle* students would be able to:

"engage in theoretical learning, reflect upon practice and enter into reflective dialogue with their mentors and supervisors" (RGU 2009a).

Unfortunately the evaluation team was not able to evaluate the implementation of this aspect as it would require access to *Moodle* discussions. The host HEI stated that they could offer paper based materials rather than students being required to access e-learning resources. It was unclear from the documentation how this would be achieved (RGU 2009a). By wishing to be inclusive there may be a risk that some students who do not have access to a computer could miss out on e-learning opportunities; they could also have reduced access to reflective discussions with lecturers and peers, and as a result it could be difficult to foster productive peer relationships and realise the *learning community* envisaged in the programme documentation (RGU 2009a).

Within phase two the questionnaire data suggested that participants' had found many aspects of the programme content useful for their preparation for the SHCSW and AP roles and in only one case had a participant reported familiarity with all the content due to previous experience. Mentorship was regarded positively by the majority of respondents.

During phase three the majority of participants, mentors and sponsors commented on the relevance of the programme for the SHCSW and AP roles in children and young people's health practice. In most cases participants had been able to access the work based learning experiences necessary to meet the academic and clinical assessment requirements. However, where work based learning experiences (i.e. practice experiences) didn't match the learning outcomes some students struggled to meet the assessment requirements. This was a particular issue for participants working with clients in their own home, in areas where the participant's role had not evolved sufficiently from administrative duties, and initially in some new community based services. Where difficulties had been recognised by mentors and sponsors remedial actions such as setting up further work based experiences had generally been undertaken, but in some cases the issue had not been fully resolved.

Aim 3: Explore the impact of new roles on individuals and the service generally

Due to the timing of phase two data collection the majority of participants had just recently started the education programme but even so many had clear views about how the programme was equipping them for their work with children and young people by improving their knowledge and understanding, enabling them to give more to the children in their care, preparing them for greater responsibilities, and providing opportunities for career progression (see Table 7: Aspirations on completing the SHCSW/AP programme on page 55).

The phase three data generally suggested that participants were gaining confidence both academically and in practice. For participants employed in children and young people's health it is clearly preferable that they have educational preparation for these roles; many had been working in child health for some time with access to in-service training, but this programme gave them the opportunity to achieve academic credit. Some referred to their improved understanding of the roles of child health professionals. Links between programme achievement and career advancement were often articulated. Some participants had aspirations to undertake a nursing programme, whilst others were considering social work roles or further academic study. One participant commented that the positive experience of studying at the HEI had encouraged her to apply to undertake a degree programme and subsequently she secured a place for the next academic year.

The impact of the programme on participants' performance appeared difficult to quantify but a sponsor reported that locally participants were able to provide better support for children as a result of undertaking the programme. There were comments from sponsors and mentors that indicated improved awareness of the requirements of client groups. Participants referred to improved knowledge and understanding of ethnicity and culture in their roles and more generally how their understanding of child health had developed. Whilst the scope of the SHCSW/AP was covered within the Capability Framework the boundaries between qualified and SHCSW/AP support staff responsibilities could be clearer. As highlighted by the Royal College of Nursing (2006) organisational structures should state clear lines of accountability, supervision and delegation of tasks within the team, support workers need to be aware of the limits of their practice and referral processes when issues are beyond their scope of practice. Some participants referred to having a 'caseload' but accountability for a particular caseload of clients and families would rest with the qualified professional, this aspect may need further exploration within the various settings where SHCSW/APs are located. Some mentors were particularly conscious of the importance of their professional accountability for non-registered staff under their supervision, and the organisation's responsibility to ensure that sufficient numbers of qualified staff were available to provide the support required by SHCSWs/APs especially in the light of current financial challenges.

The current education programme focused on capabilities in children and young people's health (CYPH) could in future identify core generic and specific children and young people's health capabilities separately so that individuals have greater opportunities to transfer skills to other settings. The CYPH competencies are mapped to the NHS KSF but it is less clear how these map to the National Occupational Standards (Skills for Health, 2009). It is therefore difficult to determine how students could progress to social care settings upon completion of the programme, despite aspirations (SMCI Associates, 2009) to bring these services together more.

Aim 4: Identify current career aspirations upon completion of programme.

In the phase two data participants were all currently undertaking the programme so for some it was difficult to predict their likely employment upon completion. The results indicated that many thought the programme was enabling them to achieve the competencies required for a SHCSW/AP role in children and young people's health and that it might improve their chances of securing a post in CYP health. The majority had considered the programme worthwhile regardless of future role opportunities in CYP health.

Within phase three participants, mentors and sponsors referred to uncertainties about the future of the SHCSW/AP role due to the financial crisis in the economy and the likely impact of this on availability of posts. Mentors acknowledged drivers for the expansion of SHCSW/AP posts were to maximise the cost effective and efficient use of qualified practitioners, but in the current situation this would be difficult to meet. Anxieties about future employment were most acute for participants working on fixed term contracts. Fortunately the majority of participants had permanent contracts that should continue beyond the completion of the education programme. Some of the latter hoped there would be 'Band 4' positions available but recognised this was not guaranteed. In future the lack of tangible rewards for students may impact on numbers coming forward for the education programme.

The need for greater preparation of the health care team for SHCSW/AP roles was noted by a few of the participants. Sponsors and mentors had in general risen to the challenge of familiarising themselves with the programme requirements but other staff may not have had access to this information. As with any new initiative it would be important to include those most likely to be affected by its introduction within the preparation, planning and implementation stages. Whilst mentors would be aware of the national drive to broaden skill mix within health care delivery teams their involvement in the current initiative had come as a surprise to some.

6.1 Conclusions and recommendations

This education programme offers a blended, flexible and accessible curriculum that integrates work based learning, learning and teaching

delivered through residential study blocks and e-learning technologies. Mentors in practice have a crucial role in supporting, educating, motivating and assessing students in practice and students' academic development is facilitated by an experienced education delivery team and high quality university library and support services. The contemporary e-learning programme materials meet the requirements of the participants. The implementation of the education programme represents a successful collaboration between academic and placement settings, and NES that can continue to be developed through the ongoing analysis of feedback from students, academic and placement staff. The programme augments skill mix in health care teams by developing individuals who can contribute to the health and wellbeing of children, young people and their families thus meeting current government policy drivers.

As this was a new programme with the added complexities of serving a geographically dispersed student population with a variable history of accessing higher education, it could be expected that there would be some problems during implementation. The tight time-frame for introducing the new programme reduced opportunities for thorough preparation of mentors in all settings, the identification and planning of work based learning opportunities was sometimes incomplete, and improved preparation of health care teams may reduce ambivalence towards new roles in some areas as the current initiative also represents a substantial cultural shift for the NHS by focusing on non registered SHCSW/APs practitioners as an integral part of the workforce. It is unfortunate that new SHCSWs/APs will be anticipating career progression at a time of political and economic uncertainty.

Recommendations:

- Clearly identify the student support mechanisms available to students

Instructions on how to access the *Centre for Student Access* are included in the *Student and Mentor Handbook* (RGU 2009c) but students new to higher education may not be familiar with the services available there. Some students may not be aware that they have specific learning needs at the start of the programme and so the effective learning service should be promoted to all participants.

- Pre-programme academic study skills

If the programme is extended to larger student intakes and/or more HEIs, it may be necessary to provide access to pre-programme academic study skills. This could include library skills, computer/IT skills, online learning, and academic writing. Procedures for self assessment of learning needs may need review.

- Clearer demonstration of how the curriculum fosters the development of generic cognitive skills such as critical analysis, and evaluation of ideas, concepts and issues at SCQF level 8

Currently generic cognitive skills do not appear to be articulated in the learning outcomes for modules and therefore written assignments assume a specific importance for demonstrating these elements. Learning activities and written assignments are of great importance for the development of generic cognitive skills within distance learning but the evaluation team did not have access to the full range of learning activities to be able to make more specific recommendations.

- Maintain and develop the education programme's peer assessment strategy

A particular strength of this programme is the intention to use peer assessment in line with the goal of fostering a *learning community*. Peer interaction indeed can enrich learning outcomes and make learning more interesting and allow elaboration of content (Biggs 2003).

- Future evaluation of the impact of the programme on roles and integration into teams

Evaluate impact of programme on students' practice one year on to focus on their role development and integration into the team since completion of programme and to investigate their role in the delivery of planned interventions in children and young people's health and their work with families.

- HEI should monitor adherence to the *placement agreement plan* with placement managers

The HEI in conjunction with placement managers should monitor the implementation of the *Placement Agreement Plan* with reference to students' work based learning experiences, mentorship and protected study time to ensure equity of student experience. For instance, some managers may require 'back-fill' for posts where students need alternative experiences to maximise learning opportunities.

- Maximise the use of learning activities during residential study blocks

Participants in phase three reported 'hands on' activities and group work were very effective for learning within the residential blocks. They also recommended that different cohorts recognised the value of meeting students in other cohorts but this could be more effective in an informal social event rather than in joint classroom sessions.

- Review the processes for disseminating information to prepare and support mentors

Few mentors were able to attend the mentors' session on day two of the initial study block and not all had received a copy of the *Student and Mentor Handbook*. The programme team should consider additional methods for disseminating programme requirements and their expectations of mentors such as through an online *Mentor Centre* and/or a *Helpline*. A separate

Mentor Handbook (in addition to a *Student & Mentor Handbook*) may be required.

Contact time with the mentor will be contingent on the location of the student and where the mentor is based in a different location this needs to be factored in to planning.

- Consistency of assessments should continue to be monitored

A consistent approach to assessment in practice and across contexts of care should continue to be addressed through the preparation and ongoing support of mentors.

- Clarification of expected levels of performance at SCQF levels 7 and 8 and within the capabilities

The programme delivery team should review and clarify the expected level of performance within the capabilities in the Capabilities Framework and according to SCQF levels 7 and 8 to emphasise the differentiation between these levels. The current heavy emphasis on cognitive components of capabilities rather than effective and affective performance of interventions may require some adjustment. Mentors also require in depth knowledge of the theoretical components of the programme due to the emphasis in the *Clinical Assessment Profile* capabilities on the demonstration of knowledge and understanding of underpinning theory. In line with quality assurance processes the *Clinical Assessment Tool* should be evaluated by mentors.

- The pass/fail criteria may require further discussion.

It is implied that students must achieve all outcomes in the *Clinical Assessment Profile* to be deemed 'satisfactory and safe' but this should be made explicit in the documentation. Mentors could find it difficult to provide an accurate assessment if the fail criteria/ performance criteria are not explicit.

'Cause for Concern' processes are articulated in the guidance for clinical documents which are available online (May 2009) but do not appear to be included in the *Student & Mentor Handbook*. Moreover the cause for concern processes are viewed as a joint responsibility between the HEI and the Employer

'To withdraw from the placement any student whose health, behaviour or action is deemed to jeopardise patients' welfare or otherwise seriously impair the placement's operations. Initiation of such action shall be immediately reported to the university' (RGU 2009c, p 4). However the role of the mentor in the 'cause for concern' process again does not appear to be explicit.'

- Highlight the HEI expectations of students prior to admission

Whilst the university and specific programme entry criteria are clear, the self assessment of perceived computer literacy and access to a computer may require review. Students need to have access to sufficient information about

the academic and practice expectations to make an informed decision about their participation.

In addition:

- The possible future expansion of this programme to other healthcare settings may require precise definitions of core and specific practice capabilities acknowledging that some capabilities may be locally determined by the requirements of different healthcare settings.
- And in relation to widespread implementation of the programme as currently designed, some consideration will need to be given to curricular content in areas such as physiology, data handling (including numeracy), analysing evidence, theories of teaching and learning, and audit.

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Appendix 1: Participants' Information Sheet



Queen Margaret University
EDINBURGH

Evaluation of Education for Senior Healthcare Support Workers (SCQF Level 7) and Assistant Practitioner (SCQF Level 8) in Children and Young People's Health with Optional Pathways

Information sheet for participants and others

We invite you to take part in a research project which we believe to be of potential importance. However, before you decide whether or not you wish to take part, we need to be sure that you understand firstly why we are doing it, and secondly what it would involve if you agreed. We are therefore providing you with the following information. Read it carefully and be sure to ask any questions you have, and, if you want, discuss it with others. We will do our best to explain and to provide any further information you may ask for now or later. You do not have to make an immediate decision.

What is the purpose of the study?

The education programme for senior healthcare support workers (SCQF Level 7) and assistant practitioner (SCQF Level 8) in children and young people's health is funded by NHS Education Scotland (NES). The purpose of this study is to evaluate the outcomes of this education programme, the appropriateness of the academic level (SCQF Level 7 and Level 8) for the support worker and assistant practitioner roles respectively, the impact of the new roles and employment patterns upon completion of the programme.

Why have I been chosen to take part?

You have been chosen to take part in the study because you have been involved in some way with the education programme for senior healthcare support workers and assistant practitioners in children and young people's health. You will be in one of the following groups:

- (a) You may be or have been a participant in the education programme or a mentor to a participant.
- (b) You may be a peer/ colleague or line manager of the senior healthcare support worker or assistant practitioner in children and young people's health.

Do I have to take part?

No. You are under no obligation to take part. However, taking part in the study will provide information that may be used to provide further educational opportunities for others, specifically senior healthcare support workers or assistant practitioners in children and young people's health.

What will happen if I decide to take part?

Programme participants

If you have been a *participant in the education programme* then you will be asked to complete two postal questionnaires at the start and end of the programme and return these within the specified time limit. If selected, you may also be invited to take part in an interview.

Mentors

If you have been a *mentor to a participant, peer/ colleague, line manager* of the senior healthcare support worker or assistant practitioner in children and young people's health, you may be asked to take part in a recorded interview with the researcher to discuss your experiences of being involved in the programme.

Colleagues/ Peers/ Line managers of programme participants

The researcher is interested in the work of the senior support worker/ assistant practitioner and may ask for your perceptions of his/ her work or role.

Will my taking part in this study be kept confidential?

Yes. All information collected about you will be kept strictly confidential. All of the information will be stripped of any identifying material such as names, places and specialities.

What will happen to the findings of the study?

The findings of the study will be reported to the study funder in the first instance and presented at relevant conferences or study days involving the target group (Children and Young People's Health practitioners and education staff) or in relevant publications.

What are the possible advantages to taking part in the study?

There are no specific advantages to you in taking part in the study however, your participation will inform future developments in education related to senior healthcare support workers and assistant practitioners in children and young people's health.

What are the possible disadvantages to taking part in the study?

There are no obvious disadvantages to you in taking part in the study.

Who is organising and funding this research?

Queen Margaret University is organising and sponsoring this research. NHS Education Scotland is funding the research.

Who has reviewed the study?

This study has been discussed with NHS Lothian Research Ethics Committee who decided that NHS Ethical Approval was not required as this is a service evaluation study.

This study has been reviewed by the Head of Nursing, on behalf of the QMU Research Ethics Committee. No objections from the point of view of medical ethics were raised 29 June 2009. The study has also been submitted to RGU Research Ethics Committee with the following outcome, "*Proposal Approved*" 10 August 2009.

What if there is a problem?

If you have a complaint about the research please contact the Principal Investigator, Dr Margaret Coulter, on 0131 474 0000

Independent Contact:

If you wish to discuss the research with someone who is not a member of the research team please contact: Dr Lindesay Irvine, Programme Leader MSc Nursing, School of Health Sciences, Queen Margaret University. Telephone: 0131 474 0000

Complaints procedure

If you wish to make a complaint about the research please contact:

Dr Kathy Munro Head of Nursing Subject Area, School of Health Sciences, Queen Margaret University. Telephone: 0131 474 0000

Thank you for reading this Information Sheet and considering taking part in this research.

Appendix 2: Programme Participants Questionnaire



Queen Margaret University
EDINBURGH

Project title

Evaluation of education for senior healthcare support worker (SCQF level 7) and assistant practitioner (SCQF level 8) in children and young people's health with optional pathways

FINAL QUESTIONNAIRE

Project funder

NHS Education Scotland

Project sponsor

Queen Margaret University

Information for respondents

This evaluation has three phases:

- Phase 1- A scoping study of programme documentation and ongoing analysis of programme data to establish the context in which the programme is being delivered, the programme content, anonymised baseline and outcome data on participants.
- Phase 2- Surveys of programme participants at the start and end of the programme (**attached here**), to record demographic data, current post, reasons for undertaking the programme, perceived levels of confidence and competence, academic background, programme content, programme delivery methods and employment patterns. The information obtained from the questionnaires will be coded to protect identities and all respondent information will remain anonymous. Contact details will be used to select programme participants, mentors and stakeholders for interview but any information you give in the questionnaire will not be exchanged with them or other participants.
- Phase 3- Qualitative interviews of participants and stakeholders to capture their experiences of the programme and investigate the nature and impact of the new roles on individuals and services.

Please answer all the questions and follow the filter questions as appropriate. The questionnaire is double sided with questions on both sides of each sheet. There is also a page at the back of the questionnaire where you are invited to add any further comments. The questionnaire will take approximately 20 minutes to complete.

WE ARE VERY GRATEFUL FOR YOUR TIME AND EFFORT IN COMPLETING THIS QUESTIONNAIRE AND SHALL ENDEAVOUR TO FEEDBACK THE RESULTS OF THE EVALUATION TO ALL PATHWAY PARTICIPANTS

The research team

SECTION ONE: Profile of Programme ParticipantCode ☐☐☐**1.1 Name¹** _____**1.2 Current post¹** _____**1.3 Programme of study***(please tick)*Senior Healthcare Support Worker, SCQF Level 7, Certificate in HE ☐Assistant Practitioner, SCQF Level 8, Diploma in HE ☐**1.4 Who are you employed by? *(please tick)***NHS Board ☐ Council ☐ Other ☐ _____
*(please specify)***1.5 Contact details²** Telephone: _____

Email: _____

First part of home post code _____

1.6 Age (years) *(please tick)***1.7 Gender *(please tick)***Less than 25 ☐25-30 ☐31-35 ☐36-40 ☐41-45 ☐46-50 ☐51-55 ☐Over 55 ☐Male ☐ Female ☐**1.8 Ethnic background *(please tick as applicable)***Black Caribbean ☐ Indian ☐Black African ☐ Pakistani ☐Black Other ☐ White ☐Bangladeshi ☐ Other *(please specify)* ☐Chinese ☐**1.9 Country of origin *(please tick as applicable)***UK: Scotland ☐ England ☐ Wales ☐ Northern Ireland ☐Republic of Ireland ☐ Other: *(please specify)* _____¹

Name is for contact purposes only, and current designation will be coded to protect anonymity

² Contact details are required for follow up interviews

SECTION TWO: Academic and employment background

Please insert the information requested in the following two tables

2.1 What is your highest academic qualification?

Level	Awarding institution	Subject	Year obtained

2.2 What, if any, qualifications are you currently undertaking?

Level	Awarding institution	Subject	Year due to complete (approximately)

2.3 For how long have you been employed in work with children?

(Please state in years or months)

2.4 Why did you decide to undertake the current educational programme?

2.5 What was your job title/ role before and after undertaking the education programme for SHCSW or AP in children and young people's health?

(please complete the table below)

	Job title³	Role and grade
a) Pre programme		
b) Post programme		

³ Job title and role details will be anonymised and used for analysis of programme cohort

SECTION THREE: Self-rating of levels of confidence in CURRENT practice

Please tick your CURRENT level of confidence applying the rating scale shown:

Rating Scale

Confident = Confident and already do this competently

Some development = Development needed in some aspects

Development = Development needed in most aspects, or all of this area

COMPETENCE STATEMENT	Confident	Some Development	Development
1. Knowledge for Practice			
1.1 The practitioner continually maintains and develops an integrated knowledge of the legislation and policy that forms the current framework in which they practice and the health and care needs are addressed.			
Understands and knows how to access relevant local policies/ guidelines, practices and legal requirements relevant to their area of practice			
Is aware of current and related legislation on equality and diversity; children's and human rights; consent			
Has the knowledge and understanding needed to support evidence informed practice			
Demonstrates knowledge of childhood developmental screening programmes for children and young people			
Shows awareness of Health Promotion Models relevant to Children and Young People commonly encountered in own area of practice			
Understands and can apply theories and interventions relating to vulnerability and abuse applicable to children and young people			
Understands the value of play in caring for children and supports learning opportunities			
2. Partnership Working			
2.1 The practitioner understands the concept of multi-agency working, ensuring effective communication,			

COMPETENCE STATEMENT	Confident	Some Development	Development
<i>continuity and consistency of Children's care within and across settings.</i>			
<i>Demonstrates an understanding of the role of others by participating in inter-professional working practice</i>			
<i>Demonstrates awareness of the importance of communication and record keeping for self and within teams and provides accurate and relevant information to children, families and colleagues</i>			
Contributes to team discussions, case conferences and reviews as appropriate and within the parameters of his or her role			
Seeks advice/ support from members of the teams within own area of practice as required			
Recognises where referral to another member of the team may benefit the child or young person, their family or carers			
3. Practising Ethically			
3.1 The practitioner can demonstrate knowledge of cultural and ethical factors influencing parenting and lifestyles and can practice in a relevant, sensitive and non judgemental manner			
Is aware of values and relevant beliefs and how this may affect practice			
Demonstrates knowledge of inclusion, diversity and anti-discrimination			
Maintains a non judgemental and ethical approach in their practice			
Respects children's rights to information, choice and self-determination, within the legal framework seeking appropriate advice from a senior where this is unclear			
Works within their Code of Conduct/ practice eg. <i>Code of Conduct for Healthcare Support Workers</i> recognising his or her own limitations and role			
4. Care and Intervention			
4.1 The practitioner develops his or her knowledge and understanding of children to contribute to the			

COMPETENCE STATEMENT	Confident	Some Development	Development
<i>assessment of the holistic needs of the child and young person, their families, carers and communities and to provide evidence- based care</i>			
Contributes to the assessment of children's needs, contributing to and implementing and evaluating individualised programmes of care with the supervision and support of the lead practitioner and within boundaries of role			
Monitors planned care within a defined caseload or care pathway and reports appropriately to senior colleagues			
Plans and prioritises own workload to contribute to the delivery and support of consistent, safe and effective care and treatment of children with the supervision and support of the lead practitioner and within boundaries of role			
Understands the effects of family and carer relationships and their influence in caring for the Children and Young People			
Is able to recognise and respond to childhood emergencies in area of practice			
Understands the needs of children and young people with learning disabilities within their practice			
Understands the needs of children and young people with complex needs and long-term conditions within their practice			
Is aware of the needs of looked after children			
4.2 The practitioner, working with others, contributes to the promotion of health and well-being, quality of life and self-care capacity for children, their families and carers			
Encourages children, their families and carers to become involved in their care where appropriate, and supports the development of self care abilities			
Is aware of sources information and advice for children and young people, their families and carers that support health and well-being, quality of life and self care capacity			
Demonstrates a knowledge of health inequalities and contributing factors/ influences			
Provides information to children and young people, their families and carers about when and how to seek specific advice and support from care professionals in line with local policy and procedure			

COMPETENCE STATEMENT	Confident	Some Development	Development
Participates in teaching and provides encouragement and support for Children to enhance their well-being and general health within an agreed care plan			
Works in partnership with families and carers to enable them to confidently support and care for children, recognising their strengths and needs			
4.3 The practitioner, working with others, applies knowledge and skills to contribute to the mental health and wellbeing of children			
Demonstrates a knowledge and understanding of mental health and factors affecting mental health			
Shows awareness of and is able to recognise children at risk due to parental mental health problems and/ or children developing mental health problems			
Promotes the mental health of children and young people where this is an identified need			
Demonstrates the ability to form therapeutic relationships with children who may present with specific challenges			
4.4 The practitioner, working with others, applies knowledge and skills to contribute to the sexual health and well being of children and young people in the promotion of positive relationships as appropriate to age			
Demonstrates awareness of factors affecting the sexual health and wellbeing of children and young people including diversity, culture and religion			
Is aware of their own belief and value systems and how this may affect their practice and interactions with people			
Is aware of the risks to the child or young person; in relationships, sexual activity, contraception, vulnerability to pregnancy/ getting partner pregnant and sexually transmitted infections (STIs)			
Works within role boundaries and competence, referring to senior colleagues, specialist worker/ service as appropriate			
Provides support to children and young people who need to disclose personal sexual and reproductive health to significant others			
Provides support and education to children and young people to reduce risk and maintain sexual health and wellbeing			
4.5 The practitioner, working with others, applies knowledge and skills to identify any circumstances that may harm the health			

COMPETENCE STATEMENT	Confident	Some Development	Development
and wellbeing of children and contributes to protection from and identifying abuse or potential abuse			
Is aware of key national and local legislation relating to the protection of children and young people			
Works in partnership with others to protect and safeguard children from vulnerability, neglect or abuse			
Is aware of how their own beliefs, attitude and experience may affect their practice and involvement in child protection work			
Demonstrates a sound understanding of what constitutes child abuse or neglect			
Acts at all times in the best interest of children and young people to safeguard their physical and psychological wellbeing			
Reports sources, signs and symptoms of danger, harm and abuse to appropriate people following local guidelines			
4.6 The practitioner continually develops and utilises interpersonal skills to facilitate effective communication with children and young people to enable them to understand their health and wellbeing			
Communicates effectively with children and young people			
Understands the importance of, and factors affecting the development of positive and caring relationships with each child, young person and their family			
Demonstrates a variety of methods of communication, both verbal and non-verbal, in a way which the children and young people can understand			
Uses appropriate language to communicate information to enable the children and young people to understand his or her health needs			
Demonstrates listening skills when communicating with children and young people			
Directs children and young people to information and support that is available to them and how to access it			
Uses play as a communication medium			
5. Personal, professional and service development			
5.1 The practitioner maintains and develops knowledge and practice by participating in life long learning, personal and professional development planning and through supervision,			

COMPETENCE STATEMENT	Confident	Some Development	Development
appraisal and reflective practice with colleagues			
Demonstrates responsibility for one's own learning through the development of a portfolio of practice and recognises when further learning is required			
Takes responsibility for identifying and supporting their own personal and professional development needs			
Gains and learns from experience by reflecting on practice to improve care and practice			
Participates in the development of local policies, protocol and guidelines			
Takes part in audits of care			
Participates in the training and support of other care workers and students under the supervision of a qualified practitioner			

SECTION FOUR: The Application Process for the Education Programme Senior Healthcare Support Worker (SHCSW), Assistant Practitioner (AP) Children and Young People's Health

4.1 When did you apply to undertake the SHCSW or AP in Children and Young People's Health education programme at Robert Gordon University?

(please state month and year)

4.2 Whom and/ or what were your main sources of information about the education programme ?

Sources of information: individuals (please tick)		Sources of information: other (please tick)	
Manager	<input type="checkbox"/>	NHS Education Scotland website	<input type="checkbox"/>
Peer/ colleague	<input type="checkbox"/>	NHS Education Scotland circular/ letter	<input type="checkbox"/>
Higher education contact	<input type="checkbox"/>		
Other (please specify) _____	<input type="checkbox"/>	Other (please specify) _____	<input type="checkbox"/>

4.3 Please give the name and contact details² of your sponsor for the education programme for follow-up.

Name of sponsor³ _____

Workplace address _____

Telephone _____

Email _____

4.4 How long did you have to submit an application, from hearing about it to the submission date?

less than 1 week ☐ 1 to 2 weeks ☐ over 2 weeks ☐

² Contact details are required for selecting mentors and stakeholders for interview but **any comments you make will not be directly relayed to those individuals.**

³ Sponsor's contact details are required for follow up interviews, please see information for respondents on page 1

4.5 What was your motivation in applying for the SHCSW or AP education programme?

(please tick all options that apply)

- 1. opportunity for general development ☐
- 2. educational opportunity ☐
- 3. opportunity for career enhancement ☐
- 4. Other ☐

(Please specify) _____

4.6 Briefly what did you hope to achieve by successfully completing the SHCSW or AP education programme?

SECTION FIVE: The programme content, programme delivery methods and assessment

5.1 Which parts of the programme content have, in your opinion, been the most useful preparation for working with children and young people?

(please state the most useful topic areas covered in the programme)

5.2 Which parts of the programme content have, in your opinion, been the least useful preparation for working with children and young people?

(please state the least useful topic areas covered in the programme)

5.3 How useful were the distance and online learning methods in meeting the programme requirements?

(please complete by ticking the relevant box)

Very useful ☐ useful ☐ undecided ☐ not useful ☐ not at all useful ☐

5.4 Please insert name and contact details of your mentor⁴

Name of Mentor

Workplace address

Telephone

Email

⁴ Mentor's contact details are required for follow up **only**.

5.5 Prior to starting the education programme for the SHCSW or AP: can you *briefly* outline your perception of the role of the mentor in the box below?

(please tick as appropriate)

5.6 Please tick the ONE option that reflects your contact time with your mentor:

- | | | | |
|---------------------------|--------------------------|------------------------|--------------------------|
| a) Every day I am on duty | <input type="checkbox"/> | d) Monthly | <input type="checkbox"/> |
| b) Weekly | <input type="checkbox"/> | e) Other | <input type="checkbox"/> |
| | | (please specify) ----- | |
| c) Fortnightly | <input type="checkbox"/> | f) Never | <input type="checkbox"/> |

(please go to 5.9)

5.7 Please tick the ONE option that most accurately describes the format of your session(s) with your mentor. The mentor session(s) were generally:

- | | |
|---|--------------------------|
| a) structured, focussing on , activities and related areas | <input type="checkbox"/> |
| b) fairly structured, with some focus on , activities and related areas | <input type="checkbox"/> |
| c) fairly unstructured, with some focus activities and related areas | <input type="checkbox"/> |
| d) unstructured, no particular focus on , activities and related areas | <input type="checkbox"/> |

5.8 On average, approximately how long do/ did your mentor session(s) last?
(please tick)

- | | |
|-----------------------------|--------------------------|
| 30 minutes | <input type="checkbox"/> |
| 60 minutes | <input type="checkbox"/> |
| 1 hour 30 minutes | <input type="checkbox"/> |
| More than 1 hour 30 minutes | <input type="checkbox"/> |

5.9 My expectations of mentorship are/ were matched by my experience
(please tick as appropriate)

strongly agree ☐ agree ☐ undecided ☐ disagree ☐ strongly disagree ☐

5.10 I find/ found the mentorship aspect of the education programme

(please complete by ticking the relevant box)

very useful ☐ useful ☐ undecided ☐ not useful ☐ not at all useful ☐

5.11 Please provide additional comment on your perceptions and experience of the education programme for SHCSW or AP in children and young people's health that may assist future programmes?

SECTION SIX: Programme outcomes

Please read the statements below and tick the responses that most closely match your opinion

6.1 Completing this programme enabled me to gain the competencies for a SHCSW or AP role in children and young people's health

strongly agree ☐ agree ☐ undecided ☐ disagree ☐ strongly disagree ☐

6.2 Completing this programme increased my chances of gaining a SHCSW or AP post in children and young people's health

strongly agree ☐ agree ☐ undecided ☐ disagree ☐ strongly disagree ☐

6.3 Completing this programme enabled me to decide that I do not wish to work in children and young people's health

strongly agree ☐ agree ☐ undecided ☐ disagree ☐ strongly disagree ☐

6.4 Overall I found the programme to be a worthwhile development experience regardless of future role opportunities in children and young people's health

strongly agree ☐ agree ☐ undecided ☐ disagree ☐ strongly disagree ☐

6.5 What do you consider to be the main *strengths* of the Certificate or Dip HE in Children and Young People's Health programme?

6.6 What do you consider to be the main *limitations* of the Certificate or Dip HE in Children and Young People's Health programme?

Please add any further comments you think may be useful.

Question number if appropriate	<i>Comment/ elaboration</i>

Thank you for completing this questionnaire.

Please return the completed questionnaire and your signed consent form using the enclosed stamped addressed envelope to:

M Coulter, Nursing, School of Health Sciences, Queen Margaret University, Edinburgh
EH21 6UU

Appendix 3: Consent Form



Queen Margaret University
EDINBURGH

Title : Evaluation of Education for Senior Healthcare Support Workers (SCQF Level 7) and Assistant Practitioner (SCQF Level 8) in Children and Young People's Health with Optional Pathways

Consent Form

**Please
initial box**

1. I confirm that I have read the information sheet for the above study.
I have had the opportunity to consider the information, ask questions
and have had these answered satisfactorily.
2. I understand that my participation in this study is voluntary and that
I am free to withdraw at any time without giving any reason,
and without my medical care or legal rights being affected.
3. I understand that data collected during the study will be made
anonymous by the researcher so that my identity cannot be traced.
4. I agree to take part in the study.

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☐
☐
☐

Name of participant: _____

Signature of participant: _____ Date: _____

Name of person taking
consent: _____

Signature of person taking consent: _____ Date: _____

Appendix 4: Semi structured interview guide



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Project Funder: NHS Education Scotland

Project Sponsor: Queen Margaret University

SEMI-STRUCTURED INTERVIEW GUIDE Version 1

Indicative content

- Preamble
- Demographic information
 - Current role
 - Role prior to starting the education programme for SHSW or AP in Children and Young People's Health
 - Aspirations for role on completion of programme
- Application process
 - How they heard about the education programme
 - Experience of the selection process
- Programme Content
 - Thoughts about the education programme, how effective/ ineffective they think it is
 - Areas they have covered in depth/ not in depth
 - Any perceived omissions
- Education Delivery Methods
 - In the programme what has worked well/ not well
 - Distance learning
 - Electronic learning
 - Academic support
 - Learning on clinical placement
 - Mentorship in practice- how the mentor was allocated, role of mentor, experience of mentorship
 - Experience of study at level 7 or 8
 - How easy/ difficult has it been for them to study at this level
 - Readiness for study
- Workforce planning
 - Views on SHSW and AP roles in Children and Young People's Health- advantages and perceived limitations

- career development
 - future service development
- Impact of programme
 - Perceived confidence across the five domains¹
 - Perceived competence in five domains
 - How the programme has affected their performance
 - Perceived impact of education programme on the way they work with children, young people and families
 - Perceived impact of SHSW and APs on service following completion of the education programme

¹ Five domains of Capability Framework- knowledge for practice, partnership working, practising ethically, care and intervention, personal, professional and service development

Appendix 5: Coding Framework